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**HIV/AIDS Prevention Interventions in Mozambique as Conflict of Cultures: the
case of Dondo and Maringue Districts in Sofala Province**

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Declaration

To my family, friends who helped me to persevere till the end,

My special thanks to my family—my husband, Dr Ramon Antonio Llapur Figuredo; my son, Muzila Xavier Malembe; my mother, Ana Moises Ngoca; and my brothers and sisters: the Monteiros. During my stay in South Africa, you missed me as much as I missed you, and you gave me all the love and encouragement that I needed till the end. Ramon, your morning and evening calls assisted me to feel connected to my home although I was far away. Muzila, your words, “mama, finish this thing,” encouraged me because I knew you wanted me to be home. Mama, “mhani wa mina”—I succeeded because of your blessing; and I believe if my father, Armindo Monteiro, was still alive, he would have blessed me equally. My brothers and sisters, I am what I am today because I know that I have people to share life with.

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Abstract

The purpose of this thesis is to report on issues concerning the continuous spread of HIV/AIDS in Mozambique in spite of the HIV/AIDS prevention interventions that are in place. This research was conducted in Dondo and Maringue districts, both situated in the Sofala Province. Sofala Province had higher prevalence that was 25 percent higher than the national average of 16.2 percent. An ethnographic research methodology was used in order to understand the reasons behind the continuous escalation of HIV/AIDS. It was significant for one to get to know the people that live in Dondo and Maringue, especially their daily lives, including their cultural practices as the driving force in people's behaviour and the manner in which people make sense of their daily lives. It was important to understand their cultural practices, because of their relevance to the issue of HIV/AIDS in terms of the manner in which cultural practices influence people in decision-making about their social life, which escalate to the issue of health practices. Although the concept of HIV/AIDS is acknowledged in Dondo and Maringue, *xirombo* and *phiringaniso* were continuously used as local concepts in health issues and practiced as indigenous knowledge together with *kupitakufa*, *kupitamabzwade*, and *kupitamoto* rituals, and these practices were extended in dealing with HIV/AIDS. The acceptance of the Western medical interpretation of HIV/AIDS was low among the people in Dondo and Maringue. This reality is due to the preservation of local cultural knowledge in dealing with diseases. As a result, local medical concept and rituals becomes a challenge to the Western medical interpretation of HIV/AIDS and its health prevention and intervention strategies. In the context of Western medical interpretation of diseases the above local cultural practices are used as

resistance against the western medical interpretations HIV/AIDS concepts. These cultural practices have preferences among local people in dealing with, and promoting HIV/AIDS health prevention interventions when compared with the public biomedical HIV/AIDS concept and the general biomedical practices. In conclusion this thesis suggests that there is a need for integration of these cultural practices within the Western medical interpretation, prevention and intervention strategies in dealing with the HIV/AIDS pandemic and its concerns at a local level.

Key words: Mozambique, HIV/AIDS, biomedical approaches to HIV intervention, cultural resistance, indigenous knowledge systems, *xirombo*, *phiringaniso*, *kupitakufa*, *kupitamabzwade* and *kupitamoto*.

Abbreviations

ADPP (in Portuguese) Associação para o Desenvolvimento de Povo para Povo
(meaning People to People Development Association)

AIDS -Acquired Immune Deficiency Syndrome

AJUPSIC (in Portuguese) Associação de Pessoas Vivendo com HIV/SIDA (meaning
Association of People Living With AIDS)

ASVIMO (in Portuguese) (Associação Moçambicana de Mulheres Vulneráveis e
Viúvas (meaning Mozambican Association for Widow and Vulnerable
Women)

CBOs Community Based Organisation

CNCS (in Portuguese) Conselho Nacional de Combate ao SIDA (meaning National
Council Against AIDS)

EN Estrada Nacional meaning National Road

FRELIMO (in Portuguese) Frente de Libertação de Moçambique (meaning
Mozambican Liberation Front

HIV Human Immunodeficiency Virus

JHU/CCP John Hopkins Centre for Communication Programme

MISAU (in Portuguese) Ministério de Saúde (meaning Ministry of Health)

NGOs Non-governmental organizations

OJM Organização da Juventude Moçambicana (meaning Mozambican Youth
Organisation)

PCAA Provincial Council Against AIDS

PVAS (in Portuguese) Pessoas Vivendo com HIV/SIDA (meaning People Living With HIV/AIDS)

RENAMO (in Portuguese) Resistência Nacional de Moçambicana (meaning Mozambique National Resistance)

SADC Southern African Region for Development

STIs Sexual Transmission Infection

TB Tuberculosis

TV Television

UCM (in Portuguese) Universidade Católica de Moçambique (meaning Catholic University of Mozambique)

UNAIDS Joint United Nations Programme on HIV and AIDS

UNDP United Nation Agency for Development Programme

UNOR United Nation Organisation for Refugees

UP (in Portuguese) Universidade Pedagógica (meaning Pedagogic University)

USAID United States of Agency for International Development

VCT Voluntary Testing and Counselling

WHO World Health Organization

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CHAPTER I: INTRODUCTION AND BACKGROUND TO THE PROBLEM

This thesis describes the socio-cultural issues that in part explain the persisting spread of Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS), in spite of the available HIV/AIDS prevention interventions in Dondo and Maringue, in Sofala Province, in Mozambique. The central argument of the thesis is that the dominant western biomedical approach is less effective in dealing with issues around HIV/AIDS, because of the following three reasons. Firstly, people in Dondo and Maringue are aware of the biomedical approach and its prevention intervention strategies to HIV/AIDS. The approach is less effective, because it is not based on people's cultural definition of health and health practices. The following concepts and rituals are central health practices among the people in Dondo and Maringue:

- *Xirombo*, a tiny or small, but a dangerous bacteria that make the blood of a human-being dirty and carry death in it;
- *Phiringaniso*, a word to name diseases including disease which has symptoms such as frequent and prolonged coughing with blood, weight loss, diarrhoea, etc;

These health concepts include the rituals and ceremonies such as *kupitakufa*, *kupitamabzwade* and *kupitamoto*.

Kupitakufa, a death cleansing ritual. This word is derived from two Sena words *pita* and *kufa*; and formulated as follows:

- *Ku* is a prefix, meaning taking an action or perform;
- *pita* is a verb meaning cleansing,

- *kufa* means death. *Kufa* is Sena word, *but* it is also common in other languages in different parts of Mozambique like Thonga, Bithonga and Ronga languages and have the same meaning as the one in Sena;
- *Kupitamabzwade*, a post-partum ritual. The word is derived from the two Sena words *pita* and *mabzwade* and is formulated as follows:
 - *Ku* is a prefix meaning taking an action or perform;
 - *pita* is verb meaning cleansing; and
 - *-mabzwade* means post-partum period; but also means cleansing of parents for a child who dies within 60 days of life; and
- *Kupitamoto*, a burnt house cleansing ritual. The word *kupitamoto* is derived from two Sena words *pita* and *moto*; and is formulated as follows:
 - *Ku* is a prefix meaning taking an action or perform;
 - *-pita* means cleansing; and
 - *-moto* means fire.

The above mentioned customary concepts and rituals are not only used in the local health system, but also in interpreting and preventing new diseases such as HIV/AIDS. For example, HIV is named *xirombo* and AIDS is named *phiringaniso*. The biomedical approach has ignored the persisting customary meanings and their use. Culture includes knowledge and practices affected by factors such as the vision of the world, language, religion, kinship, ethno-history, apart from political, educational, technological developments, and the environment where the phenomena takes place. In this way the concept of culture is complex because it represents a web of meanings to be interpreted and can be a powerful influence in people's behaviour by being a set of practices that remain for a long time. Through culture people express their needs,

values, wisdom and beliefs in a particular environment. In the context of health, cultural information has been considered irrelevant to the preventive and therapeutic intervention in health (Good & Del Vecchio Good 1980). Kleinman (1987) too supports the above claim and asserts that “the data referred to the impact of social and cultural factors are evaluated as accessories”. However as Green (1992) says the main cause of sexually transmitted diseases in different African societies is perceived as violation of norms that govern the sexual behaviours. Studies from Hielscher & Sommerfied (1985) and Nyamwaya (1987) reveal that people’s behaviour in front to their health problems including the use of medical services are constructed from their social and cultural-specific universes. In contrast, biomedicine sees illness as a physical or mental or biological or psychosocial problem (Scheper-Hugues & Lock 1987). This approach advocates that human body is a machine that can be analysed in terms of its components and the disease is seen as the bad functioning of biological mechanisms that are studied from the point of view of cellular and molecular biology. The role of medical doctor is to make interventions on the physical and chemical elements of the human body in order to fix the defect of a specific part in trouble (idem 1987). HIV/AIDS prevention interventions in Mozambique, as elsewhere, are dominated by this point of view, thus ignoring the local forms of dealing with disease.

Secondly, HIV/AIDS prevention interventions have largely focused on behavioural change advocating abstinence from sex before marriage, being ‘faithful to one sexual partner’ and/ or ‘reducing the numbers of sexual partners to a single partner’, ‘delay in the sexual debut for young people,’ and male and female condom use’. However, the behavioural strategies do not address the local cultures and practices. They introduce a

new cultural behaviour among the local people. For example, polygamy is a cultural practice among the people in Dondo and Maringue. If people within polygamous marriages stick to that particular group, they would not necessarily be infected. However, asking people who are in polygamous marriages to reduce sexual partners could generate argument and it would perhaps not be possible to them. Some studies, for example, Opong (1998) have observed that regions with high rates of polygamy in Ghana have significantly lower rates of HIV.

New interventions have been developed, for example, treatment with anti-retrovirals (ARTs), the use of microbicide, prevention of vertical transmission from mother to child, male circumcision etc, but these strategies are, however, not based on meanings and perspectives of the local people, their cultures and practices or the ways in which these cultures have changed over time and the implication of such changes. Furthermore, because of limited resources these new interventions reach only limited populations. This thesis suggests the need for public health system to engage with local cultural practices in order to effectively involve people in HIV/AIDS concerns.

Lastly, local people may 'resist' the biomedical interpretation and prevention strategies because of their 'faith' in what they consider to be their traditional practices. This creates a conflicting environment between the biomedical and traditional perspectives. It is mentioned above that local people prefer traditional practices while the public health system recognises only the biomedical approach. The biomedical approach is what is publicly recognised but the choice of traditional practice could turn the biomedical approach to be a weak or less dominating, also because the health institutions are still scarce and the majority of people continue to use traditional healing

practices to solve their health problems, including problems related to HIV/AIDS. From a biomedical interpretation of diseases, the continued practice of *xirombo*, *phiringaniso*, *kupitakufa*, *kupitamabzwade* and *kupitamoto* can be seen as a form of resistance for failing to engage the people and their way of life. This is evident, if one looks at the volume of the influence that the local cultural practices have among the local people. This influence has cascaded to the issue of HIV/AIDS; meanwhile local people prefer local cultural practices in dealing with HIV/AIDS. The above three explanations fuel the spread of HIV/AIDS, and also create cultural conflicts between the biomedical approach and local cultural practices. This thesis calls for the integration of local cultural health practices into the public health systems. An effective HIV/AIDS strategy would be possible if the prevention measures take into account both internationally recognised/biomedical approach and the local cultural health practices.

The above explanations for the persistence of HIV/AIDS in spite of prevention interventions were identified during the study on the impact of socio-cultural practices on HIV/AIDS in Dondo and Maringue. The aim of the study was to explore the reasons for the persistence of HIV/AIDS in Mozambique. Dondo and Maringue in Sofala Province were chosen because the province had a higher number of people infected with HIV than other provinces in the country during the study period. Ethnography was used as the main research methodology for this study. Participant observation, self-generated data, personal interviews, narratives and focus-group discussion and informal conversations with key informants were techniques used in data collection during a period of about seven months, organised into a number of phases.

During the initial stage of this study, the literature review and theoretical framework were used as a guide for conceptualising issues to be addressed in the study. The review continued throughout the research process. Theories such as resistance, socio-ecological theory, power, indigenous knowledge, culture, ritual, etc were used as guiding principles for conceptualising issues concerning the socio-cultural impact of the spread of HIV/AIDS.

The concept of indigenous knowledge is central in this study because it addresses a number of issues surrounding culture and its practices among local people. Culture is a central issue among people because it is how people live on daily basis, and used as a tool of interpreting actions taken in daily realities. It is important to look at issues which surround local people in the current western-interpreted HIV/AIDS challenges in order to understand the local issues and perspective of HIV/AIDS. Local people accept the biomedical interpretation of HIV/AIDS and are responding to HIV/AIDS challenges, creating their own views on and self-conceptualizations of HIV/AIDS. This situation has implications to the whole HIV/AIDS challenges or environment and also to the western or biomedical interpretation of HIV/AIDS. The local perspective on HIV/AIDS is a challenge on its own because of the domination of the western or world view on HIV/AIDS.

The biomedical perspective largely dominates in interpreting health issues at a public level but local or indigenous interpretation is also more powerful because of the far-reaching influence of local culture at a local level. These local cultural practices present opportunities for local communities to use local concepts to deal with new

challenges in health issues. The realities of using these concepts and rituals are a significant challenge to one who wishes to understand issues surrounding HIV/AIDS.

Indigenous ways of ‘knowing’ or understanding and practicing health issues have been overlooked for many years, but today, these practices are challenging the biomedical expertise on HIV/AIDS. Local people share local views among themselves more easily than they share the western perspectives because local views are equal to their cultures and it is about themselves. The sidelining of local perspectives or indigenous knowledge deepened and enriched the manner in which people view the world and this constituted a form of resistance among local people reclaiming their space in ‘knowing’ health issues, including HIV/AIDS. Local people share a lot of insights of health issues since they have been ‘resisting’ the forces of biomedical or western perspective while asserting their rights to self-determination through culture.

Xirombo and *phiringaniso* as local HIV/AIDS concepts and rituals such as *kupitamabzwade*, *kupitakufa* and *kupitamoto* create a different mainstream of HIV/AIDS concern, which has an impact to the public strategies and measures taken in dealing with HIV/AIDS issues. This is a concern to someone who tries to understand issues surrounding HIV/AIDS among local people, because within the public-accepted interpretation of HIV/AIDS, that is biomedical realities, it is a western worldview which dominates and have some unsettling consequences for the local people.

HIV/AIDS is as a concept accepted and viewed by the local people as an ambiguous term that has a western meaning. From the local people perspective, HIV/AIDS is simply a western term for naming a disease. This means that the term HIV/AIDS remains a way of naming a disease, just for the purpose of naming since it does not have a meaningful meaning to the local people. The western names and concepts on HIV and AIDS do not have power or value over local societies or culture, because local people continue to conceptualize and name HIV/AIDS using local concepts or names.

Since the first contact with westerners, local people have suffered the dominance of western culture at a public and local level, where western culture continues to try to swallow indigenous culture. Western HIV/AIDS concepts are not the first new social realities for local communities, as they have experienced years of western-culture hegemonic power over their cultures.

HIV/AIDS focused discussion should at a local level begin with realization that HIV/AIDS is not only a health issue, but also a cultural issue, that should be introduced and extended to the values, social realities/rituals and interest of the local people. This means or demands the western or public accepted HIV/AIDS interpretation to consider local interpretations and local cultures. Because of the continuation of local views of health issue at a local level, the western biomedical interpretation of HIV/AIDS is less meaningful to the local people. From the public view, western cultures have the power to dominate the local views, as it contributes to the lack of accurate meaningful and

cultural representation of local cultures, but it continues to fail in eroding these local cultures.

It is crucial to recognize local people and their cultures on public health issues or to allow local people to represent themselves on these health issues. For years, the views of the local people have been disregarded, with stereotypes and referred as primitives. As a result, this kind of social construction neglected local people to be disregarded on social realities creation and they continue to experience difficulties in promoting their autonomy and self-determination in different dimensions of the society.

HIV/AIDS creates a space for diverse experiences and perspectives to be shared in the manner in which culture is shared. It stimulates different cultures to stand for their own views and place one to imagine different views from different perspectives or cultures. For local people who are defending their local culture from the expansion of western cultural use, local HIV/AIDS concepts and rituals are tools to make sure that the world outside the local level/culture does not neglect or forget the realities that indigenous people face on a daily basis.

My findings in Dondo and Maringue communities reveal that it is within cultural issues, particularly health issues, where people witness resistance against western interpretations of HIV/AIDS. Being indigenous makes local people relearn their local cultures and maintain their connections to their way of life. The local right to self-

determination and traditional knowledge maintain local cultural identities. Local way of interpreting HIV/AIDS is just another way in which resistance continues.

The concept of socio-ecological theory is also central in this thesis as it emphasizes the influence of social context on behaviour, including institutional and cultural dimensions, which is a central concern in dealing with the issues of HIV/AIDS. It recognizes the relationship between individual and, for example, their culture. Individuals may be responsible for instituting and maintaining the lifestyle changes necessary to reduce risks in HIV/AIDS or improve health, but individual behaviour is determined to a large extent by social environment, for example, norms that a community values and other guiding principles. Problems to healthy behaviours are not only individual problems as shared among the community as a whole. The most important approach in promoting healthy behaviours that can prevent the spread of HIV/AIDS or reduce any risks to health is a combination of the efforts at all levels of the society—individual, social networks, community and public policies.

Factors contributing to the spread of HIV/AIDS are modifiable behaviours as they reflect individual health behaviours such as failing to take preventive measures like the use of condom and not getting checking his/her HIV/AIDS status. By altering lifestyle behaviours, the risks of getting infected with HIV/AIDS can be reduced. Social institutions like communities, schools, clinics and hospitals, and government organizations can support and promote healthy behaviours through policies and environmental factors such as providing information about safe sex, doing away with behaviours that are associated with sex and so on.

The ultimate goal is to prevent the spread of HIV/AIDS. Prevention requires understanding the factors that influence HIV/AIDS spread or infection. This thesis uses a four-level socio-ecological model to better understand behaviours leading to HIV/AIDS infection or HIV/AIDS spread and the effect of possible prevention strategies. This model considers the complex interaction between individual, social networks, community and government policies on health issues, specifically on HIV/AIDS strategies. It allows people to address the factors that place people at risk for HIV/AIDS infection or spread.

Prevention strategies on HIV/AIDS infection and spread should, therefore, include a range of activities that address multiple levels of the socio-ecological model. These activities should be appropriate for improving the environment continuously. This approach can sustain preventive measures or efforts made on a continuous basis.

The socio-ecological model was useful in helping to identify the socio-cultural issues, particularly cultural practices that continue to make people less receptive to western biomedical interpretations of HIV/AIDS. The socio-ecological theory illuminates four dimensions of society including social, economic, political and cultural aspects that are necessary for any intervention to be effective. The socio-ecological theory assists in interpreting the complexity of the society that emphasises actions and reflective practices that integrate a person to all dimensions of the society. It is important to consider the historical, cultural and institutional contexts of people in order to understand people's daily lives. The activities that an individual performs daily are interrelated and integrated with reference to the requirements of the society.

A community plays significant coordinating functions through cultural practices. In this study, the use of socio-ecological theory model means the social and physical settings that contextualise a person as well as the interaction between a person and social settings. This study aimed to understand how cultural practices influence people as well as how these dimension relate to one another. It is in this context, where the use of local concepts and cultural practices are identified as a form of ‘resistance’ in the context of HIV/AIDS prevention. In viewing the above mentioned situation, local people use ‘resistance theory’ as a strategy to avoid biomedical approach and its practice which also ignores their cultural practices and interpretation of disease.

The concept of power becomes relevant because questions around HIV/AIDS is a matter of relationship among people with the dominance of patriarchal system. Power it is also important to understand and interpret the relationships among people and the states and the relationship among those who have economic and political powers who are able to decide about others peoples’ life. Local medical concepts such as *xirombo* and *phiringaniso*, including ritual cultural practices such as *kupitakufa*, *kupitamadz Wade*, *kupitamoto* and *xitonga* were commonly practiced in Dondo and Maringue. Ritual is a process of legitimizing knowledge, information, behaviour and attitude of individuals into a social norm. Rituals reflect the culture of the society and they are performed based on indigenous knowledge, as the legacy of the ancestors of that particular community. Indigenous knowledge can be understood as a part of cultural knowledge (Geertz 1996). However, when it comes to development its determination is based on western ‘scientific’ knowledge. Western science and

indigenous knowledge are represented as two different knowledge systems, where western science is not only viewed as superior, but also as systematic and objective, whereas indigenous knowledge is viewed as being characterised by closed or unsystematic and primitive processes that are associated with backwardness.

The failure to recognise the value of indigenous knowledge did not only result from the dominance of western ideology, but also from the failure to understand that all different kinds of knowledge are socially constructed, and that knowledge is valued as a practical guide to the thinking around the creation of culture that is a guide to life. It became evident that local cultural practices cannot be understood without relating them to all dimensions of the society and its organisation.

Like in any other society, Dondo and Maringue districts have political, economic, social and cultural dimensions that are all central to HIV/AIDS issues. Although the main focus was on social and cultural aspects, the political and the economic issues impact on the spread of HIV/AIDS were also considered as important. It is argued in this thesis that HIV/AIDS is not only a health issue, but it is also a developmental issue that concern the country's political and economic environment. The reason for focusing on the socio-cultural context was that the cultural practices to prevent diseases including HIV/AIDS are deep-rooted in the social and cultural dimension as presented in Figure 1.

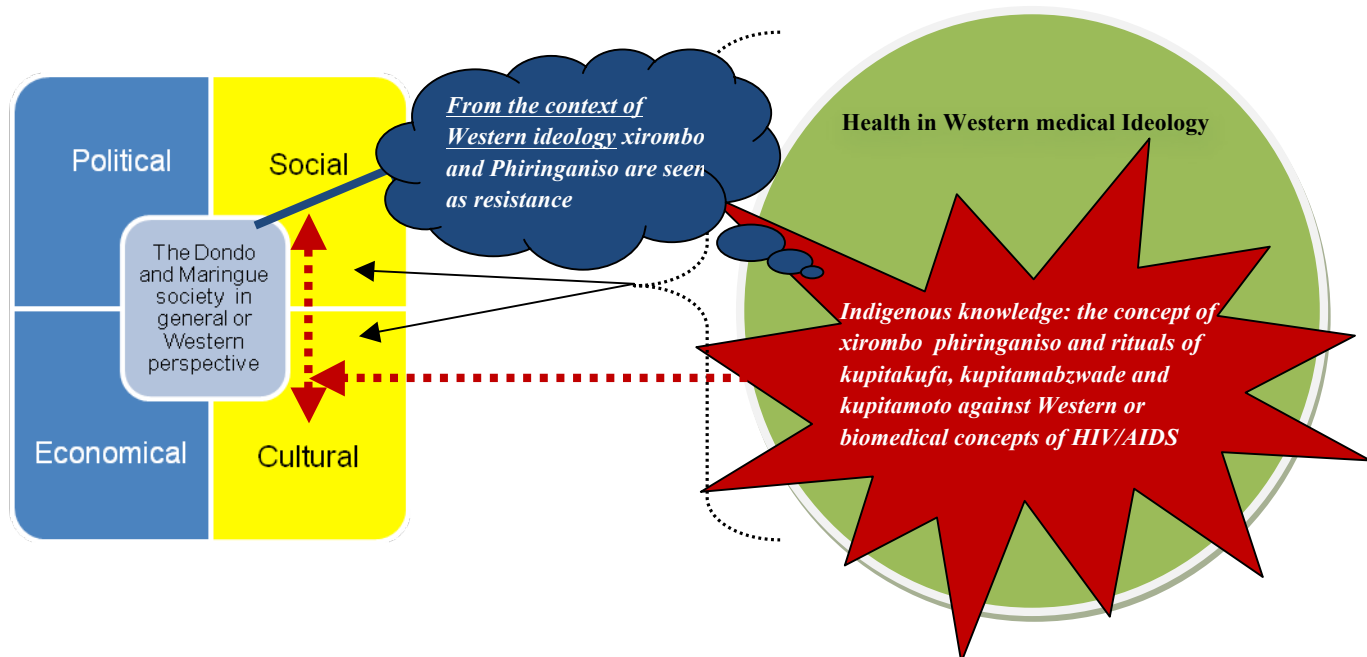


Figure 1: Contextualising the socio-cultural study of HIV/AIDS prevention interventions in Dondo and Maringue and the cultural practices that demand attention from the public health/biomedical approach.

Apart from the theories used here, previous studies on issues that have an impact on HIV/AIDS were also reviewed to gain understanding of knowledge about socio-cultural practices and their impact on HIV/AIDS. These studies include research such as the ones conducted by McFadden (1992), Casmiro and Andrade (2001), Heald (2002), UNAIDS (2002), Macamo (2003), Loforte (2003), Oinas et al. (2004) and others. These researchers strived to explain the reasons why people did not behave as the preventive messages on HIV/AIDS say. However, they failed to identify why the cultural practices persist in interpreting health issues and in making sense of daily experiences.

Western Biomedical and Local Health Concepts

In the biomedical perspective, HIV is defined as human immunodeficiency virus; while the people in Dondo and Maringue customarily define HIV as *xirombo*. *Xirombo*, according to the local people, is a tiny but dangerous thing that contaminates blood of a human being and carries death in it. *Xirombo* is associated with *phiringaniso* which is defined in similar ways as AIDS and is a dangerous disease that manifests through symptoms such as diarrhoea, lack of appetite, weight-loss, fair-hairedness and paleness. These symptoms are similar to those of AIDS but the way they are interpreted, prevented and treated is what is critical in the context of transmission of HIV. This small thing, whose symptoms are similar to the AIDS virus, is believed to occur when a man has sex with a woman who has had an abortion without performing the necessary ritual of *kupitakufa*. *Kupitakufa* is a ritual used for cleansing and preventing disease. Cultural practices including *kupitakufa*, *kupitamabzwade*, *kupitamoto*, and *xitonga* were used for interpreting, preventing and healing *xirombo*, *phiringaniso* and death. These practices were believed to cleanse all diseases including HIV/AIDS. *Kupitakufa* ritual responds to the need of prevention. It was believed that if an individual fails to clean *xirombo*, he or she will suffer from *phiringaniso*. The procedures for cleansing *xirombo* are through the performance of the *kupitakufa* ritual. *Kupitakufa* is some kind of prevention process. People believed that *kupitakufa* carries power to clean all diseases, and because of this reason, it is also used in the cleansing process of diseases such as HIV/AIDS which are locally called *xirombo* and *phiringaniso*. This implies that *xirombo* and *phiringaniso* are similarly conceptualised as HIV/AIDS, but the ways of healing are different and this is the challenge.

Furthermore, in the case of death, the process of *kupitakufa* should be performed by the widow or a widower with a relative of the deceased or through traditional medicine called *xitonga* (cleansing process). In some cases, the members of the family hire a person who has no blood relationship with the deceased to perform the cleansing process with a widow(s) through sexual intercourse. *Kupitamabzwade* is a ritual used in the context of family planning, to allow resumption of the sexual intercourse by the couple and cleansing after the death of a child. *Kupitamoto* is the ritual performed when a house burns down. This ritual is performed as both cleansing and preventing the possible reoccurrences of the event. Like in *kupitakufa* and *kupitamabzwade*, *kupitamoto* also involves sexual intercourse.

Besides the use of cultural practices, local people seek biomedicine in the public health institutions for all health-related concerns, including HIV/AIDS. Although people accept biomedicine, their daily lives in health seeking behaviour are dominated by cultural practices. When it comes to the concern on the continuous spread of HIV/AIDS local people shift the blame on media's influence on women's dressing, poverty, government and parents silence, corruption and misuse of funds intended for HIV/AIDS programmes, unemployment, and popular culture including unacceptable behaviours in shebeens.

The AIDS virus was first detected in Mozambique in 1986, in the Northern Province of Cabo Delgado. Statistical information shows that HIV/AIDS incidence and prevalence has increased ever since. Nationally, prevalence has increased from about 11% in the 1990s to 14.9% in 2002 and to 16.2 in 2003 (MISAU 2005). The government of Mozambique responded to the epidemic and established the National AIDS Council,

setting up public health education campaigns that were aimed at providing prevention information and distribution of antiretroviral treatment to People Living with HIV/AIDS (PLWHA) and established Hospital Day centres meant to provide services for people infected with HIV/AIDS. However, the strategies employed in a fight against this disease have had limited impact.

Public health education campaigns call for ‘faithfulness to one partner’ or ‘reducing the number of partners’; delaying sexual debut (particularly to young people); and the use of condoms during sexual intercourse. In 2001, antiretroviral treatment was introduced for preventing mother-to-child transmission. Although the antiretroviral programme was limited and concentrated to the prevention in the context of mother-to-child transmission, the treatment was later extended to people living with HIV/AIDS, but access to the medication was limited due to the government financial difficulties in acquiring the medication. A major government action against HIV/AIDS was the establishment of the National AIDS Council (*Conselho Nacional de Combate ao SIDA* – CNCS) in 2000. The CNCS is a multi-sectoral and multi-disciplinary institution that the government use as a tool to facilitate HIV/AIDS programmes. The institution is referred as multi-sectoral because it coordinates all the public and private institutions. It is also referred to as multidisciplinary because it coordinates and mobilises resources for the struggle against HIV/AIDS, including the facilitation of different disciplines, ranging from medical research and social science research and supporting other stakeholders involved in HIV/AIDS activities. The CNCS is responsible for the appointment and approval of HIV/AIDS related projects, including monitoring and evaluation, and revisions of all the HIV/AIDS programmes strategic objectives, including the implementation of the National Strategic Plans.

Despite the efforts mentioned above, prevalence has rapidly increased nationally. Despite the large number of people infected and being infected daily, the national healthcare system covers between 35–40 % of the population only. The partial or unavailability of health care among the people of Mozambique is one of the major reasons for high HIV prevalence. Only 15.8 % of people infected with HIV/AIDS have access to HIV testing and treatment services (MISAU 2007).

There were about 500 new infections daily, and this situation has led to a decrease in life expectancy from 46 to 38 years while, about 70% of the population in Mozambique live in absolute poverty (Hunger project 2011).currently 760,000 of women live with HIV/AIDS 760,000 (UNAIDS 2010). Other than the lack of health service for the majority of the people in the country, Mozambique also faces other problems that fuel the spread of the HIV/AIDS. Besides the cultural practices described above, there are internal and international migration; gender inequalities; commercial sexual practices, lack of formal education, ignorance; and lack of access to health care and information. New sexual practices have emerged within the migration group and affects families back home. Cultural taboos like prohibition on open discussion on sex and sexuality also contribute to the lack of sexual education between parents and children.

Nevertheless, different types of rites of passage, such as the ritual of cleansing around birth, death and other misfortunes that are performed in different regions of Mozambique may also facilitate transmission of HIV and hinder people from consulting biomedicine. Besides lack of access to the public health services, people

strongly believe in ritual performance. Rituals are generally strong institutions. People managed to resist new cultural religious practices like Christianity and Islamic belief systems because of their faith in what they still consider to be their cultural practices. Rituals assist people to resist the newly introduced cultures. A belief in a certain cultural practices, especially ritual performance reminds people who they are. People always resist because rituals are the essence and the soul of the members of a particular culture.

Nevertheless, resistance is related to the preservation of one's culture, and does not necessary mean that the processes of ritual performance are conservative. Cultural practices get updated timely with the changing environment of the society. For example, before people knew about HIV/AIDS, it was a must that *kupitakufa* ritual be performed between the widow/widower and the relative. But due to a development sense of sexual transmitted diseases, the ritual can be performed by an invited married couple and relative of the diseased without sexually involving the widow or widower. The strategy is used in order to avoid further spread of the disease. The ritual can be performed through medication without involving sexual intercourse as well. The reason for substituting *kupitakufa* sexual performance with *xitonga* (medication from roots and herbs made available by health African practitioner) is that people have realised that sexual intercourse exposes people to HIV transmission, and have therefore decided to use medication.

However, it was pointed out above that the aim of the study was to understand reasons for the continuing spread of HIV in spite of preventive interventions strategies. Cultural practices have been shown by many social scientists to be a vehicle for

spreading HIV/AIDS. This study hypothetically suggested cultural practices as one of the reasons for the spread of HIV. Prevention of HIV/AIDS is a new culture that informs people of a danger and at the same time introduces new cultural behaviour comprising of reducing the number of sexual partners and being faithful to one sexual partner, delaying sexual debut among young people, and using condom. However, this newly imposed culture did not find a space among people; if it had, people would have changed their behaviour or the manner in which they conduct themselves in relation to HIV/AIDS prevention measures.

Therefore, in an attempt to find a space among these people, HIV/AIDS prevention culture and its practices must acknowledge, recognise and respect the cultures and cultural practices of the local people. Failure to recognise and respect local cultures will continue to spark the conflict of cultures and cultural practices between HIV/AIDS prevention culture and culture of the local people. The lack of harmony between the HIV/AIDS prevention culture and local cultural practices cascade down to the issue of HIV/AIDS prevention intervention strategies, and therefore hinder effectiveness of these strategies. This situation demands that the public health approach and HIV/AIDS prevention take into account the role of local cultural practices and the first step in approaching this should be through addressing the following concerns:

- the cultural meanings of sexual practices
- the reason for the resistance of biomedical approach aimed at reducing the spread of HIV and AIDS
- the extent to which the socio-cultural aspects hinder the effectiveness of prevention intervention strategies

- the manner in which cultural practices, beliefs, norms and values fuel the spread of HIV and AIDS, and
- the relevance of cultural meanings to sexual practices to prevention of HIV and AIDS.

This research was undertaken through a case study of HIV/AIDS prevention interventions among the local people in Dondo and Maringue in Sofala Province. Beira, the Capital of Sofala Province is well developed, compared to other districts in the same province. Dondo and Beira are situated in the development corridor of Mozambique. This corridor is the main public infrastructure that acts as the enabling environment to the commercial and trade exchange practices within the country and between Mozambique and surrounding countries including Zimbabwe and Malawi, which puts Dondo in a more advantageous position, in terms of development, when compared to Maringue.

In the context of HIV prevention, Dondo is also advantageous because it is situated next to Beira. Health resources, including those for treatment of HIV/AIDS, are concentrated in Beira. The Provincial Council Against AIDS (PCAA) branch is situated in Beira. In addition, the offices of international donors are also situated in Beira and this places Dondo in a more advantageous situation with regard to resources available in Beira than the more remote Maringue.

Furthermore, the geographical location of Dondo enables cultural exchange with people from other countries like Malawi, South Africa and Zimbabwe, and internally with people from other provinces. Meanwhile Maringue is an inner district understood

as isolated from the government services delivery and infrastructures but also far from developing. Although the entire country experiences lack of essential basic services, Maringue still suffers the legacy of the Mozambican civil war. Historically, Maringue is RENAMO's headquarters and it is still difficult for the government to penetrate Maringue, due the RENAMO's dominance and influence that conserve the attitude around Maringue. RENAMO has been dominating political party as an opponent against FRELIMO. Thus social services such as running water, electricity, health and education facilities among others things are still scarce in Maringue.

Researchers on HIV have called for ethnographic studies of sexual behaviour in Africa, (Arnfred 2004; Heald 2002; Loforte 2003; Malungo 2000; Namate et al. 1997) for two main reasons. Firstly, less attention has been given to sexual behaviour and attitude to HIV transmission. Secondly, while epidemiological approaches have been effective in measuring attitudes on the prevention campaigns, there is still a need for supplementary on ethnographic approach to focus on other questions such as the contribution of culture and cultural practices on the spread of HIV. In responding to these questions, I argue that effective HIV/AIDS prevention interventions approach among local people can be made possible if the concern is tackled from the local cultural point of view as opposed to the western biomedical point of view.

Structure of the Thesis

This thesis comprise of eight chapters that are organised as follows:

1. Chapter I is the introduction that introduces the thesis to readers, providing the background of the concern around the study, its aims, study area and the limitation of the study.
2. Chapter II provides a review of literature and theoretical framework. The literature review provides readers with previous studies about the socio-cultural impact of HIV/AIDS and further provides the situational analysis of HIV/AIDS in Mozambique, taking into consideration the studies previously conducted by other researchers in the context of HIV/AIDS. Many of these studies aimed at understanding the extent to what the culture and cultural practices impact on the increase of HIV infection and hinder the effectiveness of the HIV/AIDS biomedical prevention intervention strategies. The theoretical framework assisted in conceptualising the relevance of resistance, social-ecological, indigenous knowledge, and other relevant theories. These theories were employed to demonstrate the reason for the persisting escalation of HIV/AIDS in Mozambique.
3. Chapter III discusses the methodological issues and techniques used in the study. The chapter concentrates on ethnography as an inductive method. Technically, the ethnographic method relied heavily on participant-observation, which was supported by other techniques such as self-generated data, semi-structured interviews, focus-group discussions, and narratives with different key informants such as non governmental organisations (NGOs); community-based organisations CBOs; religious groups; individual people such as students and teachers from Macharote, Dondo, Mafambisse and Emilio Guebuza secondary schools; widow; widowers, healers, traditional and community leaders, people living with AIDS; and government officials from both public administration and health sectors.

4. The research fieldwork overview is discussed in chapter IV, and introduces the health system in Mozambique through narrative stories about the history of Dondo and Maringue. The chapter does not only provide a narrative story about HIV/AIDS, but also the origin of Dondo and Maringue that nourishes the mind of the readers with historical knowledge. These historical narratives demands attention in terms of recording the necessary documentation of the history of Mozambique which is currently missing.
5. The perception and understanding of the concerns of young people on sex, sexuality and of HIV/AIDS are discussed in Chapter V of this thesis. This chapter highlights the concerns of school youth on knowledge of HIV/AIDS. It is discussed in this chapter that students portrayed their knowledge in different context of the society, ranging according to the spheres of society, such as schools, public, including HIV/AIDS programmes providers, communities and societies, including their parents. Each of the knowledge that each sphere provides, differ according to the culture of a particular sphere. The knowledge that is provided by the schools might differ from that provided by the family, because the culture of the family might differ to that of the school.
6. In exploring the manner in which HIV/AIDS intervention are organised and the manner in which the communities interpret these interventions, Chapter VI demonstrates that the people in Dondo and Maringue were aware of and acknowledged the western biomedical interpretation of HIV/AIDS and related activities. In distributing this HIV/AIDS message, a number of actors from health institutions, NGOs,¹ traditional and community leaders, donors and media were involved in spreading the message, assisting families in need of assistance, etc. But

¹ NGOs include People Living with HIV and AIDS.

the intervention approach of these actors were grounded on the biomedical approach, that include concerns around behaviour and practices like, condom use and the church-groups' call for valuing abstinence and faithfulness between partners. Both approaches impose the issue of individual behaviour change. All these approaches are not effective, because local people do not view the issue of change in behaviour as the major cause in the persisting spread of HIV, but the lack of intervention from the local or cultural practices. They blamed government for sending two conflicting messages. The government calls for a new behaviour pattern, for example, being faithful to a single partner but fails to control prostitution. Alcohol and sexual practices in emerging and existing shebeens, which are competing behaviour around sex and sexuality in the context of the persisting spread of HIV/AIDS. Media programmes were also viewed as encouraging fashion adopted by women such as "*tchuna baby*"², short skirts, and dresses, which are considered to provoke men's sexual advances. According to the communities, AIDS is the result of the lack of observance of tradition. Communities complained that prevention messages do not take into account their tradition and ways of thinking. Local prevention strategies and approaches constituted a set of rituals and sexual acts between specific partners at certain moment of life cycle or in face of certain events. It included cleansing through medicine.³ From a community perspective, the high rate of HIV/AIDS is attributed to the fact that in-depth or insider assessment of traditional methods has been neglected. This chapter demonstrate HIV/AIDS prevention as a new cultural practice which is in contradiction with the local cultural

² *Tchuna baby* is a trouser that exposes the upper part of the buttocks and the upper area of the female's private parts. This fashion spread over Mozambique in 2000.

³ Medicine from roots made available by traditional healers.

patterns of prevention. An examination of cultural conflicts is imperative for understanding the spread of HIV in Mozambique. The design of effective HIV/AIDS prevention campaigns should not only use the biomedical approach, but should also recognize local cultural aspects. It is discussed in this chapter that people were not only able to describe the HIV/AIDS prevention intervention activities, but they also made critical analyses about them.

7. Chapter VII discusses the need for applying local knowledge to the HIV and AIDS as a critical challenge in order to avoid imposing practices; and rather involve people and respect their own local cultural practices. Apart from recognising and acknowledging the biomedical ideology on health, including HIV/AIDS prevention interventions, people in Dondo and Maringue continued to use their local knowledge on health issues, and these practices are also extended to the issue of HIV/AIDS.
8. Chapter VIII has the Conclusion and Recommendations presented in it.

CHAPTER II: LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

The HIV/AIDS pandemic has become a complex problem in the whole world. According to UNAIDS (2010) an estimated number of 33,300,000 adults and children were living with HIV in 2009. Interestingly, poor countries have a larger percentage of the number of people infected with HIV/AIDS globally. For example, and according to the John Hopkins Centre for Communication Programmes/JHU/CCP (2003) about 24.5 million people infected by this disease live in Africa and 22.500 million in Sub-Saharan Africa (UNAIDS 2008). Since African countries are less developed when compared with European countries, and the fact that HIV/AIDS is concentrated in Africa helps one to conclude that the pandemic is both a health- and a development-related problem. It seems that the problem will remain unresolved and becoming a dire problem every day in the near future and it will become worst, if compatible strategies and appropriate measures are not applied. The pandemic is a global problem, but it is experienced differently in different countries. Different experiences among different countries suggest that HIV/AIDS pandemic need not only to be dealt globally or to use a one-size-fit-all strategy or measures, but require local strategies and measures that can respond to issues concerning local people. This chapter brings in the issue of HIV/AIDS in a global context and demonstrates specific issues that are experienced uniquely by developing countries, particularly African countries like Mozambique.

The chapter also demonstrates how different social theorists interpret the situations affecting African countries particularly on the issue of HIV/AIDS. The purpose of the chapter is to demonstrate issues that have not been addressed by many theorists and to

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emphasises the significance of my study. A number of theories were used in this study as guiding principles towards situational analysis of issues emanating from the spread of HIV/AIDS among the people of Dondo and Maringue, such as resistance and socio-ecological theory, power, indigenous knowledge, culture, rituals, sex and sexuality, etc.

HIV/AIDS: A Health and Development Problem

The HIV/AIDS epidemic has become a serious health and development problem around the world, particularly among the developing countries. We have seen above that HIV/AIDS is concentrated more in poor countries. The UNAIDS report (2010) shows that in the world 2.6 million people were infected with HIV in 2009, which is almost 20% less than the 3.1 million people infected in 1999. According the report, there has been a 20% reduction in new HIV infections in the last 10 years. In the most-affected countries the prevalence of the pandemic reduced by more than 25% because young people are adopting safe-sex measures.

Although the HIV/AIDS pandemic is seen as a universal problem, the impact of the pandemic on Africa is heavy (McFadden 1992). About 20% of the entire adult population, from the ages of 15–49, is currently infected in the nine southern African countries of Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. This is a staggering statistic with most of the infected with no knowledge of their HIV-status. Many people discover their HIV status at a late stage, when they are not only HIV positive, but are also suffering from AIDS. In Mozambique statistical information has been showing that incidence and prevalence rates have grown ever since. National prevalence has increased from about 11% in the 1990s to 12.2% in 2000 and 12.5% in 2001 to 13.1% in 2002. This number increased

to 15.5% in 2004 and declined to 11.3% in 2007 (PENIII 2009) and the last figures from INSIDA (2009) shows the prevalence of 11.5% in adult women and men. No cure is available for AIDS yet, and the disease threatens the social and economic well being of this country (USAID 2000).

The Global Conflicts with Local Perspective

According to Susser (2009) HIV/AIDS is a product of long-term human interaction in a rapidly changing world. She further says that HIV/AIDS is exacerbated by global process as Parker (2001) and Scheopf (2001), cited in Susser (2009) assert that AIDS knows no border. It is discussed in this thesis that the local people in Maringue accuse people travelling outside Mozambique for bringing in HIV/AIDS.

There are different views on HIV/AIDS and its prevention intervention strategies. The differences are identified when one tries to understand the meaning of HIV/AIDS from different approaches, such as the western biomedical perspective and the local perspective. Despite identifying the two conflicting cultures in the conceptualisation, HIV/AIDS has to be viewed from the political and economic dimensions. This is to say that HIV/AIDS is not only a social or a health issue. It is also a problem of development. The impact of HIV/AIDS seems to be less in the developed countries compared to the developing countries. In the first world the western ideology concentrates attention on biomedical approach to HIV/AIDS pandemic predominantly as a health issue (Marais 2000; Van der Vliet 2001). The biomedical approach dominates the entire world, but it has a less acknowledgement in the developing countries, particularly in African countries. The central focus in the biomedical approach is about the need for establishing or finding a cure or vaccine that should be made freely

available by the public health care, while affordability of drugs in the public health care and the lack of vaccine has remained unresolved (Van Donk 2003)

Historically, African countries have been marked by chronic economic, political and social crisis. The biomedical approach that was adopted to tackle the pandemic mismatched the politico-economic and the socio-cultural status of these countries. According to McFadden (1992), the problem with HIV/AIDS is the tendency to see and define the disease as a medical problem with emphasis on sero-epidemiology while attention to historical, social and cultural factors has been limited. The gaps in the literature of HIV/AIDS reflect several inherited problems in the history of the medical research in African countries (Burton 1983). The neglect of these other factors is partly due to the fact that medical research conducted in Africa has been carried out using standardised western tools of analysis which do not accommodate different and complex cultural, social and political dynamics (Bulmer 1993).

Oinas (2004) supports Burton's argument when she asserts that the social, cultural, economic, religious and other differences within different countries have been disregarded. Methodologically, the study of HIV/AIDS has long been located within a biomedical perspective, (McFadden 1992). McFadden further argues that the challenges that people are likely to face in the twenty-first century include a growing recognition of the problems posed by the AIDS epidemic across the African continent and in the world, which can no longer be treated simply in medical terms. McFadden (1992:159) argues that "one of the consequences of medicalising the problem of AIDS resulted in a poor understanding of the socio-cultural characteristics of HIV transmission and its life-threatening implications for those infected". The dominance of

western biomedical approach did not start with HIV/AIDS, but during colonialism, which dominated not only people and their cultures, but also their minds in the manner in which people interpret the meaning of their actions.

The 'superiority' of western culture was made possible due to the poor understanding of the dominating group about the dominated people, where the question of the 'us' (–the civilised) and the 'other' (–the exotic low culture) never got a clear or compatible methodology that could make it possible for the two groups to understand their cultural differences and diversities. The western culture continued to dominate the African culture, assuming that Africans and their cultures are inferior. As a result, the so called 'exotic' low culture remains central in terms of being the unit of analysis. This led to the lack of integration between the western and local cultures which did not only pave the way for the biomedical dominance, but also the continuation in neglecting the importance of finding the critical points for intervention, including in the current HIV/AIDS prevention interventions.

The continued increase of AIDS in Africa has shown that the disease has to be challenged and defeated, through a broad and serious commitment from each country but not neglecting the global perspective. Thus, various governments have been encouraged to generate local strategies and to have a multi-sectoral approach giving responsibility to different actors such as NGOs, civil society, media, religious groups, healers, health and other governmental institutions, and scientists from different scientific disciplines (AIDS Analysis Africa 10(3) 1999; Joint United Nations Programmes on HIV/AIDS 2002; AIDS Analysis Africa 10(4) Dec.1999/Jan 2000). The implementation of voluntary counselling and testing (VCT) services, and the

promotion of condom use also play a major role in HIV/AIDS prevention. A concern on individual people changing the sexual behaviour and creating effective social networks for effective communication was also implemented. Southern African countries such as Botswana and South Africa organised campaigns against HIV/AIDS (Heald 2002) that were intended in focusing on local issues and using local approaches.

According to AIDS Analysis Africa (2000) African governments recognised HIV/AIDS as local problem and as a result, multiple approaches were adopted and implemented. However, in most African countries, including Mozambique, the HIV/AIDS prevalence is still too high when compared with that of the first world countries. But the challenge or the question of the high prevalence and the persisting spread of HIV among the developing countries remained blurred among policy makers and implementers on issues regarding health, including HIV/AIDS, because the approaches that are adopted and strategies that are implemented do not take into account the local issues from the local approach or point of view.

HIV/AIDS Prevention Initiatives in Africa: case studies of selected African countries

Although African governments and external donors such as UNAIDS, USAID and WHO have tried to provide answers to HIV/AIDS, their explanations have not been sufficient. Besides governments and the donors, researchers and theorists on HIV/AIDS provide explanations on the persisting spread of HIV/AIDS and present variety of difficulties that African countries face.

Local Issues in Poor Countries Bounce Back to the Global Perspective

The situation discussed above, about the experiences of HIV/AIDS among African countries, suggests that these countries must find their own ways of dealing with HIV, that is, how to combine the biomedical perspective with the views that acknowledge the importance of understanding the disease from a local point of view. In Mozambique, apart from a significant body of literature on the impact of cultural practices on the spread of HIV, few focus on the use of traditional methods for preventing disease including HIV/AIDS. However, some researchers, such as Macamo (2003), Arnaldo (2003), UNAIDS (2002), Casimiro and Andrade et al. (2002), Santos et al. (1993), Loforte (2003) have conducted research on sexuality, identifying some cultural practices that were declared to be contributing to the spread of HIV/AIDS in Mozambique. This section of the chapter reviews some of the literature on the effects of cultural influences on the spread of HIV/AIDS in Africa. The literature on the impact of cultural practices provides a position to interpret and understand the people's behaviour in Africa.

According to Scheopf (1995) HIV/AIDS is a global problem and a disease of development—'under' or 'uneven' development. Scheopf associates HIV/AIDS with the economic problems among African countries. Relating HIV/AIDS to the economic status in African countries is said to have started during colonisation, characterised by lack of recognition on local cultures and now heavy debt burden. According to Webster (1984) the general trend has been towards a historically informed analysis of the economic, political and cultural dimensions of social change. While still recognising the importance of the interests of a capitalist economy as a global

determinant, Webster acknowledges that at national and local levels such interests are shaped by and have effect through the normal political and cultural institutions such as the families, communities, kinship relations, etc.

A case study of people in the northern Kilimanjaro, in Tanzania shows the perceptions of local actors about the historical and demographic processes to be surrounded by symbolic association of HIV/ AIDS (Setel 1996). Setel wrote that when AIDS emerged in Kilimanjaro region in 1984, many Chagga people—the dominant ethnic group in this region—viewed the pandemic as a curse from the ancestors. This view differs from that of some social scientists, who views HIV/AIDS as a 'disease of development'. Social scientists associate HIV/AIDS with development particularly the poor economic development and urbanisation in African countries; slow or lack of adaptation of modern lifestyles and poor health services that need serious attention. Some of these social scientists view the persistence of African cultural practices as the problem that hinders development and stimulate the spread of HIV (Caldwell 1989).

The Chagga people viewed HIV/AIDS as a punishment from the ancestors for a failure to honour their culture. Some social scientists suggested different strategies on addressing the problems of HIV/AIDS in Africa, for example, the social and cultural context of understanding of sex and sexuality has occur at a number of discussions (McFadden 1992; Bujra 2000; Bond and Vincent 1998; Ankrah 1993; Webster 1984) about the impact of social and cultural issues on HIV/AIDS.

In Malawi—a country neighbouring Mozambique to the west, the AIDS epidemic is responsible for large numbers of death every hour (UNAIDS 2008). According to

UNAIDS (2008), out of the total population of nearly 14 million, almost 1 million people were living with HIV at the end of 2007 (UNAIDS 2008). AIDS is the leading cause of death among adults in Malawi, and a major factor in the country's low life expectancy of 43 years. In some areas of Malawi, HIV/AIDS is still a taboo subject and as a result, discrimination among people infected with the disease is common (Pembrey 2009). People in Malawi are still not well informed about HIV/AIDS (Namate et al. 1997). High-risk behaviours are prevalent, because of ignorance about HIV/AIDS and people resist from changing their sexual habits, due to their cultural beliefs (Namate et al. 1997). The fact that the government failed in developing HIV/AIDS programmes and providing resources, such as sufficient condoms for the prevention (Namate et al. 1997) has worsened the situation.

Studies have identified multiple and concurrent partnerships and transactional sex as key drivers of HIV transmission in the sub-Saharan region (UNGASS 2010). These studies have also suggested that a potential driver of the epidemic might be certain practices (GoM 2005) that act to expose individuals to the risk of getting the disease (MOH & NAC 2003; Matinga & McConville 2004, Malawi Human Rights Commission 2005; Kadzandira & Zisiyana 2006). The UNGASS (2010) report shows that cultural practices are a significant challenge to HIV/AIDS prevention strategies in Malawi. In some cases, interventions have aimed to substitute risky cultural practices with "healthy practices" (Kornfield and Namate 1997). According to the UNGASS report, a study conducted in Nsanja district reported several cultural practices that expose people to HIV infections. According to Kadzandira & Zisiyana (2006) the following rituals are viewed as risky practices and are performed in this district:

1. *Kulowa kufa* or *kupita kufa*: This is a death cleansing rituals. During *kulowa or kupita kufa* a widow or widower is culturally obliged to have sexual intercourse with a nominated man, who should be a younger brother or an elder brother or any other relative depending on the status of the person to the family. In this case, the nominated man cannot be an elder of the family. The ritual is believed to have power to protect the relatives and whole village from different kinds of misfortunes and to please the spirits of the ancestors. Recent studies have also reported that in the case where there is no male within the family, a member of a community is hired to perform the ritual. However, the report does not clarify how the cleansing is done in case of a widower.

2. *Bzwade*: This is a cleansing ritual that is performed to strengthen the body of a newly born child. The parents of the child perform the ritual through sexual intercourse, but in cases where the father is not available, a man who is a member of the community is commercially hired to perform the ritual (UNGASS 2010:39).

The report reveals that these practices are also common in most parts of the southern African region and in the last couple of years, various newspaper articles have reported on numerous cultural practices in various parts of the country as exposing people to HIV transmission.

3. *Chokolo*: This is a ritual performed for one to inherit his deceased brother's wife.

4. *Fisi*: This a ritual performed to 'heal' childless in couples and to introduce sex to newly initiated girls and cleaning methods used during circumcision (UNGASS, 2010).

While some studies have reported a decline in these cultural practices, other studies indicate that the practices still continue, but in privacy, as those who continue the

practices are afraid of being humiliated by individuals and organization opposed to these practices (Munthali et al. 2003).

A qualitative study conducted in three districts of the southern African region (UNGASS 2010) also revealed that young girls indulge in premarital sex, as part of the initiation ceremonies or rites of passage. Traditionally, when a girl passes the rite of passage, she is allowed to be introduced to a new life stage that is adulthood. During the rites of passage, girls are taught lessons on sexual performance in order to please or satisfy their future husbands or perform better on bed work (Kadzandira 2010). During the lesson, no sexual penetration is involved, however some kind of lessons were kept in secret to male and girls who have not enter the initiation and women who did not pass by the rite.

In Botswana, cultural beliefs have been viewed as playing a role in the spread of HIV/AIDS (Heald 2002). Heald said that cultural beliefs are not linked to the manner in which the government elaborates health policies, an exclusive approach that ignores the voices of ordinary people. People in Botswana see HIV/AIDS as a disease existing since olden times, but re-emerges due to the disrespectful practices, a failure to pay tributes and to please ancestors. According to Heald (2002) and Onias (2004) the biomedical approach, including prevention interventions used in AIDS are not positive to the local communities. It is obvious that the limited effectiveness of the biomedical approach and its prevention intervention strategies lie in biomedicine as a western approach, and also because of the manner in which people have been introduced to it. A top-down approach is used in introducing people to HIV/AIDS prevention. As a result the message is not well received, because the information is imposed on the

people, since people are not involved in the planning and the implementation processes. It is obvious that combined elements are hindering the effectiveness of the current biomedical approach and its prevention intervention strategies. The current approach is not effective because people lack the knowledge or ignore the HIV/AIDS messages imposed onto them. Ignoring the message appears to be a form of resistance. People continue to make sense using their local cultures. The reason for continuing with local cultural practices is that local people are able to make sense of their world and through the interpretation of their cultural practices. The Botswana government has introduced a prevention campaign, which stresses the use of condoms, but according to the local people the strategies used in HIV/AIDS campaign were considered as an invitation to promiscuity (Heald 2001). Churches and parents resisted the messages of condom use. Their reason for resisting condom use was a belief that condom use promotes sex before marriage. Heald, therefore, asserts that the situation had an impact on AIDS and created a crisis of governance in Botswana. Currently Botswana and Malawi are witnessing the increase of HIV/AIDS in the region.

Cultural norms such as funeral rites, rituals for twins, succession and reproductive rites, together with the sexual partner sharing in polygamous marriages remain cherished as cultural value-systems for local people (Ndolerire et al. 1994). Child bearing is crucial among the African people, as the only way in which parents project their immortality into the future. The cultural practice of taking over or inheriting the deceased brother's wife or a widow allows unsafe sexual relationships. All of these practices are rational decisions (Vargas 1997), influencing and dominating in the manner in which people make sense of their daily activities. This thesis argues that the

cultural practices are valued, and for which reason alone, people are not willing to let go of them.

For example, taking over the deceased brother's wife is practice to ensure solidarity among the members of the family. In this case, the children of the deceased are protected and remain full members of the family. Furthermore, the name, carried by these children would not only preserve the name of their dead father, but also that of the entire family. The cultural practices are thus meaningful to the people; for which reason the people continue practicing them even when opposed or criticised. To understand these cultural practices, including why people continue to subscribe to them, one needs to be in par with the thinking of these people. There is a need for one to understand that there is no better culture than other cultures, one culture becomes superior when it is compared with the next. A perfect culture does not exist; every culture is subject to amendments, in order to fit into changing circumstances. Without making amendments, that particular culture would not be able to fit in any changing environment.

In general, all sexual relations can become risky depending on the adopted behaviour or the conduct which can expose them to risks or help them to avoid these risks. Taking over a deceased brother's wife was seen as cultural practice to allow solidifying the widow and her children to a secure and stable environment, but HIV/AIDS did not exist then. Today, the practice is viewed as one reason why HIV continues spreading. The question is, is it a practice that is risky or the way/process of performing this practice? It was made clear that the lifestyles among African people are dominated by local cultural practice, and it is not easy to replace local cultural practices with global

cultural practice although culture is dynamic and in constant permeability and changeable. The question of addressing African people to change from their cultural practice that are thought to fuel the pandemic remains.

A Situational Analysis of HIV/AIDS in Mozambique

According to the Mozambique Agenda 2025 Policy (2003), the prevalence of HIV infection in Mozambique would be between 15–20% by 2025. In 2010, Mozambique had 62,603 orphans, (Portal do Gov. de Moçambique 2006); 154,000 children live with HIV in the country (REDICEM 2011), 1.6 million lives with HIV from the total population and within those 55.5% are women and 9.2 % children with age under 15 years (PENIII 2009). In the country there are 170,000 newly infected cases and 96,000 deaths from AIDS (PENIII 2009). The HIV/AIDS target groups is everyone who is sexually active, but women are more likely to suffer from HIV/AIDS than men. Susser (2009) demonstrates how gender issues play a role in HIV/AIDS spread among women. She asserts that women are likely to carry HIV/AIDS virus and they contract HIV/AIDS in their early teens, on an average ten years earlier than men (Abdool Karim and Abdool Karim, 2005; Barnett and Whiteside, 2002 cited in Susser (2009)).

The failure for policy to pay attention to the role of the cultural practices in the current prevention interventions partly explains why these prevention strategies have not succeeded in reducing the spread of HIV/AIDS. Santos and Arthur (1993), Casimiro (2002), Loforte (2003), Macamo (2003) and Arnaldo 2003 have raised the elements of cultural practice that have impact on HIV infection. However, they have not offered

clear explanations. Their studies indicate a combination of elements, where cultural practices such as initiation rites and religious beliefs mainly from the Catholic and Muslim religious faith associate sexual relations with procreation. According to Santos and Arthur (1993) “women are represented simultaneously as weak, fragile and as ‘dirty and impure’”. The practice of unsafe sex with different partners, mainly by young girls is also seen as resulting from poverty and destruction of social values. The extra-marital relationship practice is common among migrant workers whose wives are left in the rural homes exposes both partners to risk of infection with HIV (UNAIDS 2001). According to the local people, there is a relationship between the use of condoms and lack of respect as a result of which they refuse to use condoms. Condom use failure is also an issue of gender power inequality. In Dondo and Maringue women tend to receive HIV/AIDS information before their partners, during their consultation with health service providers during pregnancy, childbirth and immunisation of children or other avenues such as the women’s daily reproductive roles/activities in the households and communities. As a result, HIV/AIDS becomes a central concern to the women’s daily lives. But due to the position of a woman in the household and in the entire society, woman fails to influence decision-making. The situation is difficult for women, because of lack of power to make decisions in their households and in their communities, and therefore, they are not able to negotiate for condom use with their partners or husbands. Men view condom use with a wife or a partner as an offence. They assume that if a woman asks her husband to use a condom, it means that the wife or a partner is in this context, questioning her husband for cheating.

The patriarchal social norms accept that a woman’s sexual relation must be acceptable only in the context of marriage and procreation (Santos and Arthur 1993). Traditional

values that dominate in families and in the society, place a woman in the subaltern position, which negates her capacity to protect herself from HIV/AIDS and other sexually-transmitted infections (STIs). Andrade et al. (2003) argues that women's submission to the model of domination is characterised by the social limitation of sexuality and procreation rights. Social scientists view the position of a woman in the society and in the family as a confirmation of social practices that contribute to the spread of HIV/AIDS. However there is little discussion on how indigenous cultures react to new cultural patterns of HIV/AIDS prevention, including the kinds of local strategies that have been constructed in dealing with this complex and a challenging situation. Durham (1991) argues that "no matter how small and insignificant the information, at the one end of the spectrum, nor how grand and encompassing, at the other end, what is socially taught and learned is part of culture". Durham indicates that culture is simply a complete collection of socially transmitted information within a society. This is the reason the issue of HIV/AIDS is generally associated with sex and sexuality, values, and belief systems and it is significant to contextualise these issue to different dimensions and spheres of the society because the approach takes into consideration the importance of understanding what a particular issue means in different context and spheres.

To summarise, the issues identified in the studies about HIV/AIDS prevention provided interesting lessons because they illustrate significant strategic approaches in dealing with HIV/AIDS. Strategies have different success, depending on how serious and committed governments are concerning the reduction of the HIV/AIDS prevalence. Although individual countries have adopted different strategies they continue to neglect the importance of socio/culture in HIV/AIDS prevention strategies. As a result

of this failure the prevalence rates of HIV/AIDS among these countries are still high. Apart from Botswana and South Africa which are in better condition although they also have problems, the majority of African countries have similarities in terms of scarce resources and a variety of difficulties inherited from the colonial system. Although not equal in form, all African countries have a similar historical, social and cultural background. Furthermore, they all depend on external aid for health related programmes, including programmes for HIV/AIDS. This thesis argues that the dependency on external donors means that HIV prevention strategies are influenced by their ideology, in this case, the western ideology. In this context, it can be argued that the failures of African governments to take account of local cultural practices are in some ways influenced by these funding institutions. The money does not come without pre-conditions on how it is to be spent. In this case, proposed strategies and approaches to be used in the project determine access to funding. The manner in which countries access funding from external donors, where certain agreements on certain approaches are put in place before the approval of funds, often determine the kinds of approaches and strategies to be implemented. It is unfortunate the imposed approaches are detested because of the powerful influence of local cultural practices among local people.

Mozambique is considered as one of the poorest countries in Africa. Statistics show that the spread of HIV/AIDS will intensify within the next few years if the government fails to change the current approaches and strategies in tackling the disease. This requires use of different research tools that help to accommodate local cultural practices. The campaign against HIV/AIDS in Mozambique is clear in the context of understanding why and how the conflicts between indigenous and the global cultures on HIV/AIDS prevention make the fight against HIV/AIDS transmission difficult. It is

obvious that HIV/AIDS has created a platform for exchange of information between different countries in sharing knowledge to fight the pandemic, but this platform is dominated by the western or biomedical approach. Depending on the approach, local cultural contexts can effectively contribute towards the fight against the disease.

Sub-Saharan Africa remains the epicentre of the global AIDS epidemic with a large number of people living with HIV/AIDS (WHO 2008). HIV/AIDS prevention remains a major challenge among the African countries.. Although researchers such as Loforte 2003, Macamo 2003; Arnaldo 2003; Casimiro 2002; and Santos and Arthur 1993 raise important elements related with cultural impact on HIV infection in Sub-Saharan Africa, including Mozambique, they do not offer clear explanations on how these local cultural practices have impacted on the spread of HIV/AIDS in the country. Their arguments are in line with the work done by Scheopf (1995), Webster (1984), Setel (1996) and other social scientists who have written on HIV and AIDS. Scheopf views AIDS as a disease of development and ‘under’ or ‘uneven’ development that resulted from Africa's experiences with colonialism, and heavy debt burdens, and other colonial problems, but she has been unable to describe the local reasons that could fuel the pandemic. Webster (1984) sees the interests of a capitalist economy as global determinant which are shaped and have effect at national and local levels through the indigenous political and cultural institutions. Nevertheless his analysis is limited because he is not specific in terms of determining the institutions involved. Setel (1996) contextualized AIDS with development and the role of cultural practices in influencing the spread of HIV, but failed to see that it is not the practice that influences the spread, but the manner in which the procedures are carried out. Thus, writers, such as McFadden (1992, Bujra (2000), Bond et al (1997) Bond and Vincent (1997), Ankrah

(1993) and Webster (1984) suggested different strategies to address the problems of HIV/AIDS in Africa. The suggestions are the result of the occurrence of discussion at all levels indicating the understanding of sex and sexuality within social and cultural contexts. Heald (2001) indicates people's lives as deeply regulated by a set of *meila* (taboos) and as deeply regulating people's life that have an impact in changing behaviour on HIV/AIDS and as a result, there is a mixture of many sexual transmitted diseases.

Researchers in Mozambique pointed cultural practices such as initiation rites and religious beliefs that involve related sexual relations to procreation and polygamy as generating the spread of AIDS. Santos and Arthur (1993) argue that subordination places women in positions of practicing unsafe sex. The extreme levels of poverty places young girl into risky of sexual practices, especially intercourse with different partners. According to the UNAIDS journal (2001) extra-marital relations that are practiced outside of traditionally regulated mechanisms render migrant workers and their wives vulnerable to disease. Casimiro (2002) linked the use of condom with the lack of respect. As a result people become resistant to the practice of safe sex. According to Santos and Arthur (1993) the fact that there is social acceptance that women's sexuality must be within marriage and procreation and the dominance of moral community/traditional values in the families and society, situate a woman in a risky position without capacity to protect herself from HIV/AIDS and other STIs. Andrade et al. (2002) argues that the position of woman in the society contribute to the spread of HIV/AIDS. A study from UNGASS (2010:39) in Malawi linked the practice of multiple and concurrent relationships, including transactional sex, as the key drivers of HIV transmission in Malawi and in the entire sub-Saharan Africa region. It was also

emphasized in some studies that “cultural factors” (GoM 2005) or cultural practices are placing individuals in the risk of contracting the disease (NAC & MOH 2003; Matinga & McConville 2004; Malawi Human Rights Commission 2005; Kadzandira & Zisiyana 2006).

The UNGASS (2010) report, which was a study that assessed sites and spaces where people meet new sexual partners in Nsanje district, argued that cultural practices such as *kulowa kufa* or *kupita kufa*, and *bzwade* (Kadzandira & Zisiyana 2006) expose people to HIV infection. While some studies have reported a declining prevalence in most of the cultural practices because of the massive campaigns on HIV and AIDS and gender-based violence, some studies have uncovered and reported that the cultural practices are still dominating in African countries, although in some areas they are practiced illegally. In Botswana, cultural beliefs play a role in the spread of HIV/AIDS (Heald 2002), due to the top-down approach in dealing with issues of HIV/AIDS that ignores the voices of local people. According to Heald (2002) and Onias (2004) the language used in AIDS is based on western science or biomedical approach and as a result it limits the effectiveness of the programmes against HIV/AIDS. My research thus explored local perceptions from the context of local cultural practice, and strived to understand the local meanings of different kinds of cultural practices including rituals and the impact of these cultural practices on the current HIV/AIDS prevention interventions. The complexity of this study required the use of multiple research methods and different participants in order to understand persistence in the spread of HIV/AIDS. The thesis does not only demonstrate the empirical data that was identified in the context of cultural practices, but also assists towards the understanding of the meanings and interpretations from local people on HIV/AIDS prevention

interventions. In order to get an understanding of HIV/AIDS prevention interventions in Dondo and Maringue, the study was based on the following two basic theories:

- (a) The theory of resistance; and
- (b) Socio-ecological theory.

The resistance and socio-ecological theories are discussed in the context of HIV/AIDS prevention, in order to understand the reasons for the failure of the current prevention and interventions strategies, which are effective among the developed countries.

Reasons behind the Spread of HIV/AIDS: ‘Resistance’ reveals Real Issues for the Spread of HIV/AIDS in Mozambique

The power of cultural conflict is influential and brings confusion among social actors. Cultural conflict emanates from the recognition of cultural difference, particularly from disparities between two or more competing cultural practices/behaviour and social and historical forces that serve to shape the culture of a particular society. Cultural conflict is therefore a divergence between the values, behaviours and power of the dominating culture/group with that of the dominated culture/group. In the context of the HIV/AIDS prevention interventions study in Mozambique, biomedical approach, as it is dominated by the western culture, conflicts with local cultural health related practices. The biomedical approach dominates over the local cultural practices, and as a result, creates a chaotic the social environment. People find themselves in a situation where they have to accept or reject one or all of the two conflicting cultures. The conflict between the biomedical and local interpretations of health, including HIV/AIDS prevention in Mozambique requires an understanding of the theory of resistance and of power. It was through the process of enculturation that people of Mozambique

historically accepted the biomedical interpretation of health. This enculturation took place during colonialism, where western ideologies became the dominant culture as imposed on African people. The power of western ideology became dominant and 'accepted' as a norm. But the domination of the western culture did not manage to eradicate local cultural practices. Local people 'accepted' the dominating cultural practices, but continued with their local cultural practices. The persistence in the use of local culture conveys both overt and covert messages to the dominant culture and this shows that local people value their culture. The messages from the local culture to the dominating culture can be interpreted as a form of 'resistance' behaviour. The word resistance demands careful distinction between passive and active resistance. In this case, passive resistance would mean ignoring the message and active resistance would mean voicing out the concern and rejecting the message. In this case, the basis of resistance results from the imposition of a culture on a people. In this study, the term relates to the rejection of the use of HIV/AIDS preventive measures. The use of traditional cultural practices means active resistance to the western culture or biomedical approach. Local culture resists and 'rejects' the message from the biomedical approach. Local people acknowledged the biomedical approach, but acted upon the situation in order to protect the borders of their culture. With consciousness that their cultural practices would be discontinued, local people resisted and this was done through the acknowledgment of western cultural practices, and with the continuation of the use of local cultural practices. The acknowledgment of western cultural practices was just a way of coping with their subordinated social and cultural position but also way of preserving their local culture.

As a result of conflicting cultural practices, local people describe the spread of HIV/AIDS differently from the biomedical approach. They use indigenous health cultural practice and beliefs. The existence of different interpretations of HIV/AIDS has locally led to confusion and speculations about the meaning of HIV/AIDS, including interpretation preventions approach.

In her study in South Africa and in Namibia, Susser (2009) argues that local people lack knowledge about HIV/AIDS due to lack of education. Susser says that people with resources, knowledge and options to change their lives can protect themselves or seek treatments. This maybe generally true but is not the case among the people of Dondo and Maringue in Sofala Province of Mozambique. People of Dondo and Maringue have knowledge about HIV/AIDS and some have access to biomedicine, however not all of people with such knowledge and access to medication rely on, or only on biomedicine, as they choose to live according to the culture of their environment/society.

People of Dondo and Maringue, locally understand HIV/AIDS in a number of ways and these understandings involve the following accounts:

- HIV/AIDS is a disease spread through condoms, where people believe that condoms carry in them diseases. The use of condoms promotes promiscuity. This belief has emanated mainly from Christian religious groups.
- HIV/AIDS is a disease transmitted through unsafe sex and spread through the having of sexual intercourse with multiple partners. This is the biomedical interpretation of the HIV/AIDS. Biomedical interpretation is not just limited to HIV/AIDS, but also to the entire public health system.

- HIV/AIDS is caused by failure to comply with local cultural practices, e.g., having sexual intercourse with a woman who has terminated a pregnancy; or having sexual intercourse with a widow or widower who has not yet performed the cleansing rituals.
- According to the local people, HIV/AIDS is a disease that exists since the olden days. The disease re-emerged because people do not practice or honour their cultures. As a result, HIV/AIDS is known locally as *shirombo* (HIV) and *phiringaniso* (AIDS).

Susser (2009) focused on the social conditions or aspects that contribute to the epidemic such as poverty, access to medication or treatment, etc. Social conditions are one part of the aspects that contribute to the epidemic among the Dondo and Maringue communities, as local cultural aspects play a major role in their way of dealing with diseases, including HIV/AIDS. It is clear that the health environment among the people in Mozambique is complicated. This complex health environment requires one to understand how people think and react against a new cultural practice, in this case, HIV/AIDS, but also the way people interpret same situations in different ways, including the reasons behind these different interpretations. As Susser (2009) argues that globalization has not displaced the ingenuity and agency of people and groups at the local level. For example, women in Southern Africa have agency to form social movements to voice out their concern. The same applies among the people of Dondo and Maringue; the global or biomedical approach on health issues, including HIV/AIDS have not made people change from using their local culture to define, interpret and describe health issues.

According to Ripmeester et al. (1998), resistance can be defined into two separate categories: “directly oppositional struggle: transcendental social action (often revolutionary), and unorganised, oppositional micro-practices described as everyday resistance”. Scott (1998:32) asserts that “everyday forms of resistance share with the more dramatic public confrontation and intend to mitigate or deny claims made by superordinate classes or to advance claims vis-à-vis those superordinate classes”. Resistance is a struggle by a physical and discursive terrain that is continually fragmented, fractured, incomplete, uncertain, and the site of struggles for meaning and representation. In Mozambique people adopted different strategies of resistance, both passive and active, as strategies towards coping with conflicting and challenging situation. The strategy has been used from the time of colonialism and even in the post-independence era that have caused the civil war. In the current democratic era, these different forms of resistance are practiced depending on the objective. Scott (1985:31) shows that different type of resistance can be seen as “non-compliance, subtle sabotage, evasion and deception”. During the annual review of the health strategic plan (2005–2010), it was understood that the pandemic is increasing at a fast rate, due to the fact that HIV is not only transmitted by sexual contacts, but also other ways of transmission such as blood transfusion, mother-to-child transmission, health workers, particularly nurse come into contact with blood infected by HIV, etc. This included the lack of respect to norms of bio-security in the health entities for vaccination, injections and blood transfusion. However, it was said that people still resist behavioural change; hence, there is need to pay attention to the cultural practices in Mozambique. Scott (1985:38) argues that “the intentions and consciousness are not tied in quite the same way to the material world as behaviour is”. Resistance is in constant mutation and adaptation, and the ways in which people create a resisting form of communicating,

which has to be understood in the context of the spread of HIV/AIDS in the country. This requires thinking around resistance and attention to consciousness of local people towards inquiring the reason for their actions. In Dondo and Maringue the western biomedical interpretation is acknowledged but cultural practices and their rituals such as *xirombo*, *phiringaniso*, *kupitakufa*, *kupitamadzwide* and *kupitamoto* are similarly practiced for preventing diseases. The persistence in the practice of this culture is a way of resisting biomedical perspectives. However, lack of communication and interaction among policy makers on HIV/AIDS has failed to realise the importance of involving people in order to make people understand the message from the biomedical culture on HIV/AIDS.

The Cultural Pattern of HIV/ AIDS Prevention Interventions in Mozambique

The pandemic in Mozambique as elsewhere in the world challenges the notions ingrained in the preventive interventions. There is an assumption that communication should take place using a single cultural approach, while HIV infections occur in different contexts with different ethnic groups, cultural practices, languages, religious and values with different local meanings of sex and sexuality. HIV and AIDS prevention becomes a complex issue because people view, perceive, name and react differently to the environment. The notions of cultural practice are also interpreted differently with different meanings, which are derived from different cultural perspectives. The same applies to the interpretation of HIV/AIDS, which is interpreted differently by different social actors. Landy (1977:1) addresses this complexity as she argued that “there is an inexorable linkage between disease, medicine and human culture”. For this reason, the HIV/AIDS situations are interpreted differently from the cultural point of views. It is, therefore, necessary to illustrate the complexity of

interpretation of cultures including sex and sexuality in Mozambique using the theory of complex cultural context in the cultural field as presented in Figure. 2. The interpretations assist in understanding the local issues that fuel different cultural behaviour among the people of Mozambique.

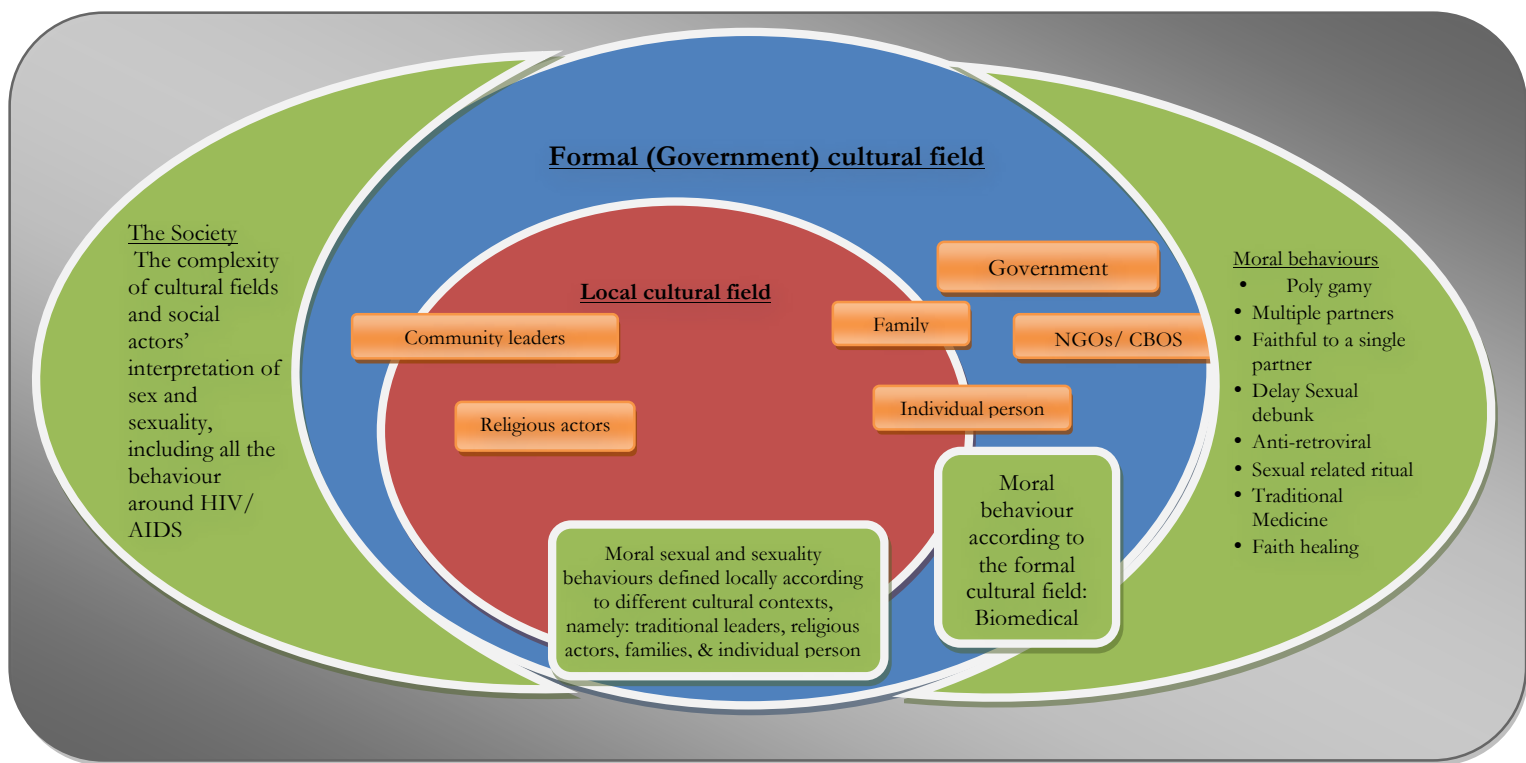


Figure 2: *The complex cultural context in the research field*

Figure. 2 is the representation of the complex contexts within which people live and make sense of their interventions and meant to contextualise individual's actions, including the meaning of these actions. The culture around interventions and intervention agents is also complex with different actors who represent different perspectives and, therefore, a dense network of values, beliefs and commitments in relation to HIV and AIDS and its prevention. The message about prevention is conflicting, because when the health and health-related institutions and organisations advice people to use condoms, powerful religious institutions challenge the notion of condom-use because condom use, according to the Christian morality is a transgression. This is a public discourse that has an impact on the culture of the people. Other than the diversity that resulted in confusion, people resist in various ways, depending on their interaction with the message and the messengers. There are different arena from where people can learn about HIV/AIDS 'realities', and there are more perspectives that can be used to interpret the issue of conflicting culture that was identified from this study. Figure 3, presents different actors in the field of HIV/AIDS as the main messengers in spreading news about HIV/AIDS.

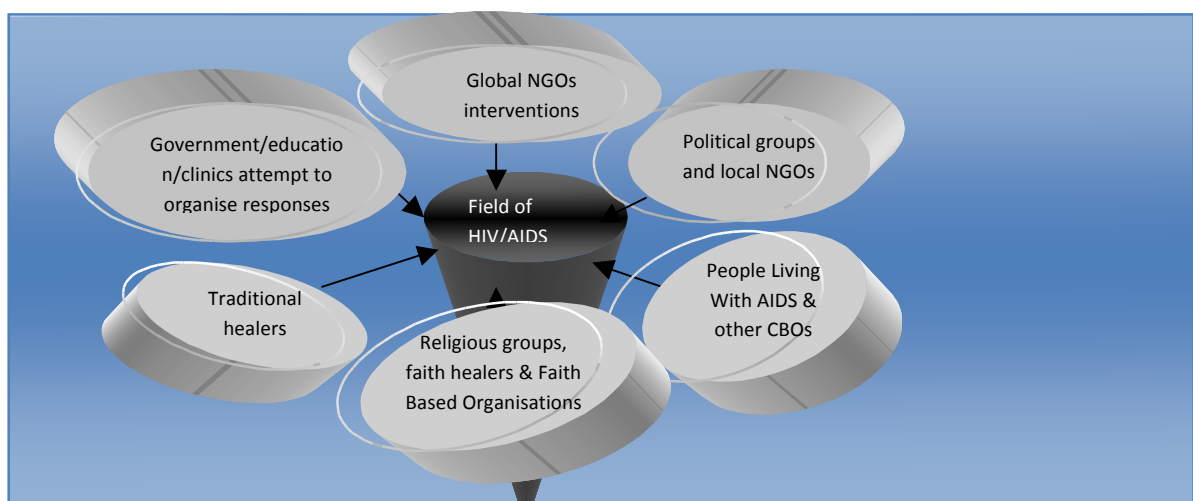


Figure 3: *The intervening agencies, actors and institutions in the field of HIV/AIDS*

The position of sending message from these actors is determined by existing conflicting cultures. It is in this context where the concept of resistance is used to denote a state of action in relation to HIV and AIDS-related interventions and may take different shape given the historical contexts and the phenomenon. It was previously argued that there are different kinds of resistance and in this case resistance results from contradictions arising from reasoning from different cultural contexts.

This demands a careful observation in order to get a clear understanding of the type or form of resistance. In this study the term resistance does not have a direct meaning of rejection or refusal, but as “unorganised, oppositional micro-practices described as everyday resistance” (Scott 1985), which arise when people get conflicting messages. People may react because of confusion, especially where the messages fail to address their concerns about HIV/AIDS. People ‘passively’ resist, and ignore the information, because these messages conflict with the way they interpret and view the issue of sex and sexuality.

The Socio-ecological Theory

The socio-ecological theory was used in this study to demonstrate that health issues should take into account different social environmental factors. Figure.4 from the Centre for Communication Programme Johns Hopkins University⁴ demonstrates other factors impacting behaviour around health and HIV/AIDS related issues.

⁴ The HCP South Africa is a local NGO. Johns Hopkins Health and Education in South Africa provides technical assistance and financial support to 16 local institutions working at the national, provincial and local levels in order to build their capacity to design, implement,

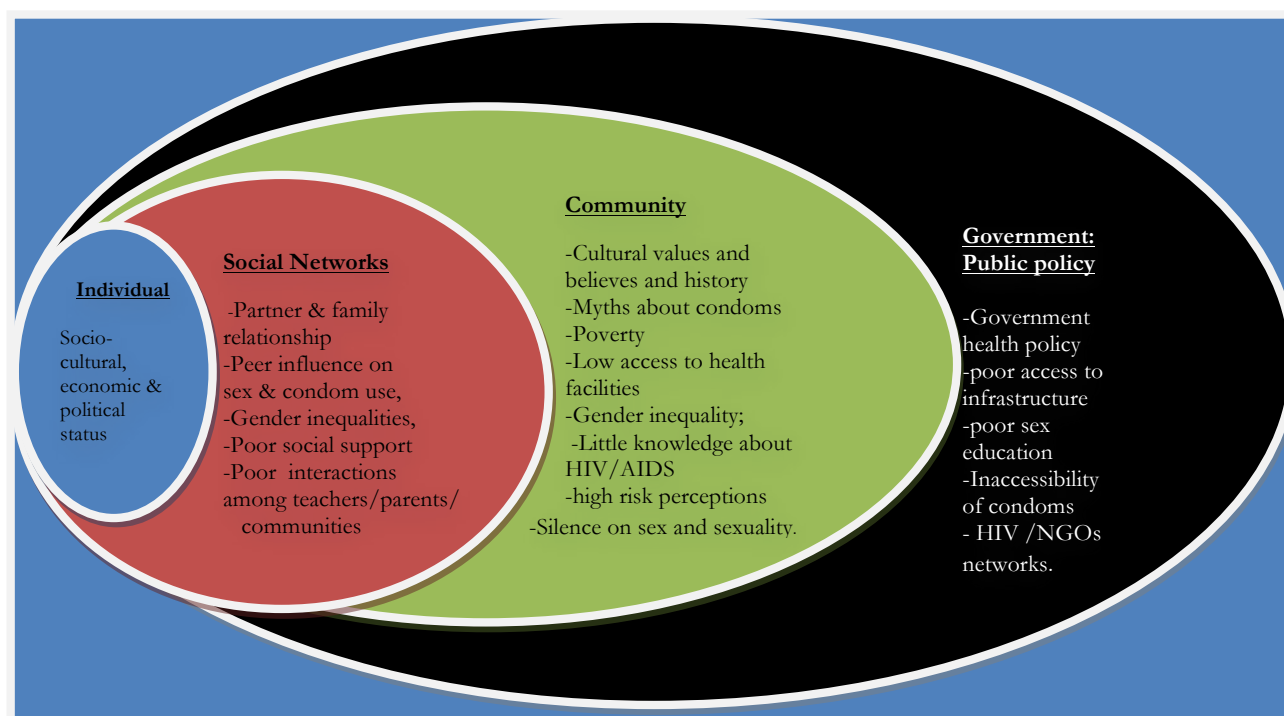


Figure 4: *Socio-ecological model of society on the issue of prevention*

The socio-ecological theory assists in interpreting the complexity of the society that emphasises actions and reflective practice that integrate a person to all dimensions of the society. It is important to consider the historical, cultural and institutional contexts of people in order to understand their daily lives. The term ecology is a descriptive word that is applied to complex relationships between organisms (Hawley 1950) and their environment that fosters and supports the creation of communities (Siemens 2003). There are several adaptations of the social ecological model. Bronfenbrenner's perspective (1979) on ecology was based on the person, the environment, and the continuous interactions between the two. Bronfenbrenner's work was an additional work done by Lewin (1935) on classic equation. Classic equation shows that the monitor, evaluate, and manage HIV- and AIDS-related behaviour change and communication programmes in South Africa.

behaviour of an individual depends not only on the person, but is also influenced by the environment. Bronfenbrenner considered the individual, organization, community and culture as nested factors. Relevant scientists who contributed to the field include the work done by Amos Hawley (1950) on the concept of “interrelatedness of life”. This demonstrates the relationship of an individual with the society as a network that can be meaningfully examined. The activities that an individual performs daily are interrelated and integrated with reference to the requirements of the society. A community plays significant coordinating functions through cultural practices. The continuing increase of HIV/AIDS in Dondo and Maringue districts can not only be viewed in the context of individual behaviour or in the cultural context, but also in sense that social resources play an important role towards the decrease of the pandemic. HIV/AIDS prevention interventions should take into consideration the relation of an individual to all the levels of the society. The socio-ecological theory assists in thinking around the patterns of activities, social roles and interpersonal relations that are experienced from particular physical, social, and symbolic features (HCP 1994).

In this study, the use of socio-ecological theory model means the social and physical settings that contextualise a person as well as the interaction between a person and social settings. The reasons for bringing in the socio-ecological theory in a study, about HIV/AIDS prevention interventions among the people in Dondo and Maringue is that the ecological theory assist in assessing the central concern in a holistic approach, rather than concentrating on a single context or sphere of the society. It is a misleading notion to assess the problem from a single context, because all the contexts of the society are interrelated and have equal influence to a culture and individual people. Assessing issues pertaining to individual and neglecting issues pertaining to social

networking, community and public policy interventions cannot give a broader picture of the problem. The socio-ecological theory demands that the concerns of the society should be tackled in a holistic way as presented in Figure 4. The purpose of looking at the central concern in a holist way is to identify the interrelatedness of the structures of the society and how these structures influence each other. In using the socio-ecological theory on the issue of HIV/AIDS prevention interventions strategies, the behaviour behind the continuous spread of HIV/AIDS among the Dondo and Maringue communities was tackled from the different structures of the society. This thesis suggests that in addition to taking into consideration different contexts of the society, the intervention should not be intended in changing the behaviour of a particular social structure, e.g., cultural practices, but to work from that particular cultural practices' point of view. It is a fallacy that the biomedical approach and its intervention preventions strategies aim at changing the behaviour of people and their cultures. This thesis further argues that the central concern, in the case of HIV/AIDS prevention interventions should be to encourage and facilitate harmony between the conflicting cultures of the society. For example, in the context of social health environment, as presented in Figure 5, the biomedical approach, as the dominating culture, conflicts with the local health culture.

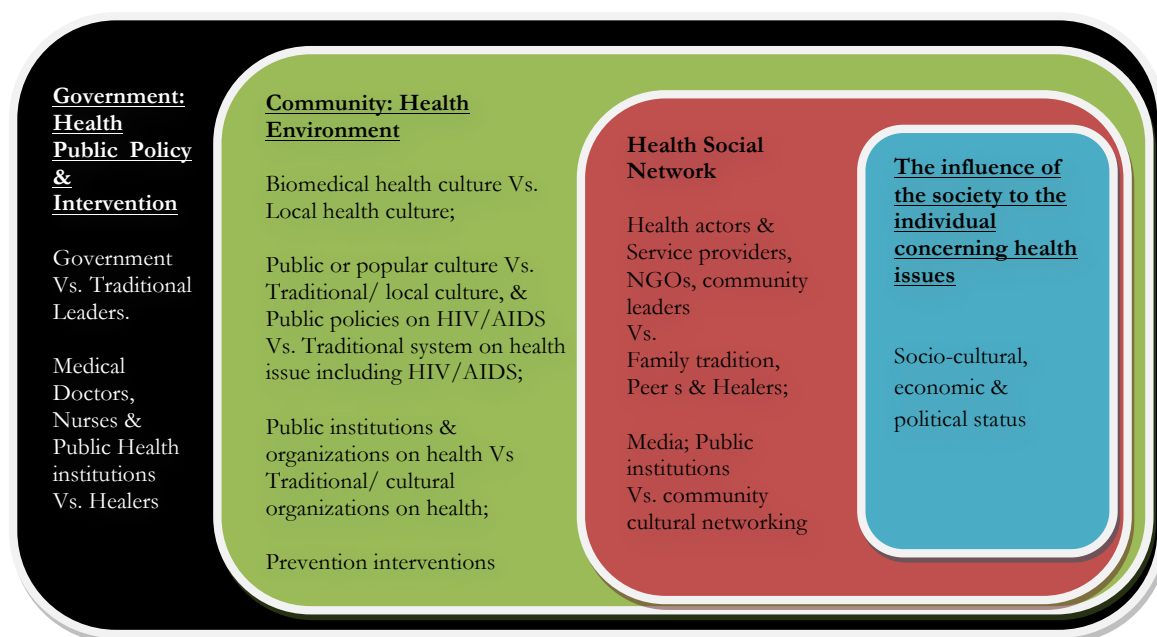


Figure 5: *The socio-ecological model of HIV/AIDS prevention interventions*

The public health approach uses the global culture of HIV/AIDS prevention interventions and fails to contextualise this approach into local cultural contexts. The use of socio-ecological theory would not only assist in dealing with the major concern in a holistic way, but would also help in the understanding that the environment of the society is composed of conflicting cultures that make it difficult for the members of the society to assess the suitable culture for making decisions in their daily lives. The concern in this context is to accommodate all existing cultures in order to negotiate their relations. HIV/AIDS prevention interventions should be built on existing practices, skills and be familiar with the behaviour of the local people. The intervention should be culturally compelling, in order to engage local communities and be located within their social and ecological background. HIV and AIDS can, as a cultural phenomenon, be viewed from a cultural domain (Landy 1977). Culture is defined as a force on human action (Barth 2002) that shapes the individual's ability to survive in a

society with diversity. This is the reason culture is said to have a potential to cultural identity that gives the meaning of life. Ife (1999) argues that culture is dynamic, and cannot be separated from the person. Culture has in it old values, but at the same time acquires new values, and during the process of acquiring new values, old values get missed out. These values and norms are assumed to have a potential to influence individual's lifestyle, including the behaviour on sex and sexuality. Sexuality is a complex phenomenon and a dynamic concept. It is socially constructed, linked to religion, cultural environment, power, etc., and have different meanings in different milieus (Thornton 2003). Sexuality is viewed as a tool for masculine control and violence (Foucault 1978) and it is thus associated with gender relations. Gender refers to the socially constructed differences between women and men. Gender allocates power and privilege and defines interactions between men and women. These patterns, in this case relation, should be determining the current health or HIV/AIDS approach, including the prevention interventions strategies. Fornas (1995:1) points out that "cultural phenomena are shared with others, being means of inter-subjective intercourse and communicative action". Cultural phenomena are said to have both "routes and roots" (Fornas 1995:3) because they have many directions, and there is "no single root that explains such phenomena fully and no single route that sums up its total meaning and effect" Fornas (1995:3). Cultural pattern illustrate the type, the model of the culture and its complexity that can be defined as a web of flows, multiplying, converging and crossing.

Culture, Gender and Power relations

It was demonstrated in the above that culture, for example, cultural relations involve power and for this reason culture can be used as a form of resistance in a society with

diverse cultures. Culture consists of the abstract values, beliefs and perceptions of the world that lie behind people's behaviour and that are reflected in their behaviour. Members of the society share values, and when they act, these elements reproduce behaviour that is intelligible to other members of that society (Haviland 1999:35). Culture does not only give identity, but also deals with problems that concern people. Culture satisfies the needs of the people due to its potential and capacity to change and bring new circumstances or altered perceptions, and it is as a result interpreted and perceived according to the environment. It is relevant to locate the role of researchers in HIV/AIDS experience and talk about culture with "those who live by its rules" (Haviland 1999). In this case, researchers can help to explain how people behave and what is necessary to influence changes in a certain environment and how to approach them.

In anthropology, HIV/AIDS is seen as a cultural domain and phenomenon (Landy 1977). The concerns of the study are framed in the cultural context. Culture is a force directing human action (Barth 2002) and shapes the individual's ability to survive in a world of diversity, to live in order to create a cultural identity. Culture is viewed as something that must be preserved (Ife 1999), and for this reason it cannot be separated from a person. It reacts to external forces that tend to impose new rules of behaviour. The individuals' social environment plays a role in guaranteeing the acquisition of cultural values that guide social behaviour. The individuals' behaviour is in accordance with the socio-cultural environment, because people receive values that are the focal point of social interaction (Ife 1999). Culture is also linked with reproduction, as a means of recreating humans (Thornton 2004), and for this reason, people or

communities cannot separate sexuality from reproduction. In this regard, sexuality becomes an element of culture and cultural practices.

Although gender is not a focus of this study, there is a need to elaborate on it because of its relation to power, sexual relations and behaviour that concern HIV/AIDS. According to Caldwell et al. (1992) the complex matrix of social norms and the power differences based on gender relations are being perceived as the reasons that limit a woman's capacity to refuse unsafe sexual practices. In the society that accept the power of a man over a woman, the most important and valuable behaviour is that a woman should, in the relationship, give sexual pleasure to the husband or partner. It does not matter what the consequences of the act would be, these actions result in increasing the body's vulnerability to infections. These values are legacies of the social environment transmitted from one generation/culture to the next and they contribute to the increase of HIV/AIDS. The deep assimilation of these values depends on age, sex and other kinds of knowledge acquired through social development. HIV/AIDS is a disease that came to create a cultural revolution without precedent. People have various sexual behaviours, which in daily life constantly exposes them to HIV. The adjustment and adaptation to external conditions of existence is revealed as a complex mechanism when assessed in the context of sex, which takes place in "the space of dual" (Thornton 2003). The changes that take place in the cultural context result from the reaction to new cultural patterns. This is an action with new elements and a complex process, because the perspective and interpretation of meaning depends on defunct ideology. Thus, people can view the reaction to the new insights in a positive or negative way. The same applies to the issue of HIV/AIDS prevention measures, where people find themselves in difficulties to understand and adopt the biomedical approach of

HIV/AIDS that demand changes in behaviour. The issue to be addressed in this case is to find the strategies that will be compatible and convincing to the people and these strategies should be formalised from the local cultural point of view.

It is important to remember that talking about HIV/AIDS be viewed in a positive way, for example, it demands a review on the current gender relation approach. A new gender relation approach that can fit in the new cultural pattern of HIV/AIDS prevention intervention measures is required. The initial stage towards the new gender relation should be an inquiry on the issue of decision making, including decisions on sexual relation that currently denies women rights to make decisions about their future. The acceptance and adoption of both the global and local forms of prevention towards new cultural pattern of HIV/AIDS prevention will also modify the interaction between women and men giving more space for sexual negotiation that would challenge the traditional power relation between men and women of different cultures. This will not only challenge individual cultures, but also be a challenge to governments to reinforce popular cultural norms about how people should behave in their private lives and in public, including how government can strengthen its intervention to the space of dual. Patton (1994), cited in Oinas (2004), is concerned with the manner in which scientists and policy makers exercise their power in reproducing “masks of otherness”. The HIV/AIDS pandemic highlights the new form of power relations that translate into a more global process between the rich and the poor countries. The concept of power means different things in different contexts. It is clear that the concept of power in terms of the relation between men and women, especially where the man has the power to control is relevant to the study of HIV/AIDS. This would mean that the position of a man, as the position that control the process of production and reproduction and even

the process of “recreation” (Thornton 2003) constitutes a unique domain of human freedom. There is a relationship between the private and the public setting, and as a result, government decides on the type of behaviour people should live, but this does not mean that people accept all behaviours that are defined by the government. It is necessary that the decision that governments make should be grounded on the culture of the people in order to be well understood and adoptable. The same applies to the issue of HIV/AIDS approach, including prevention intervention strategies which would only be efficient if the process of implementing them recognised the culture of the targeted group.

Prevention as Knowledge and Action Against Ignorance in the Context of HIV/AIDS

Prevention is an ongoing process of promoting the individual's, the family's and the community's growth and potential in order to reduce any kind of problem. According to the WHO (1984), prevention may take two-pronged approaches that are:

- (1) A deliberate and constructive process designed to promote the growth of individuals and communities toward a full human potential;
- (2) The countering of harmful circumstances such as health and safety hazards, family stresses, job pressures, isolation, violence, economic hardship and inadequate housing, medical services, or childcare.

The President's Emergency Plan for AIDS Relief (PEPFAR)'s approach on prevention focuses on ABC—abstinence, be faithful and condom use (Susser, 2009)—is one of the major examples in providing prevention measures on HIV/AIDS worldwide.

PEPFAR is a programme used by United States of America (US) for prevention and treatment, and has been adopted by 15 selected countries. Preventions measures discussed in this thesis goes beyond the PEPFAR's ABC as prevention among the people of Dondo and Maringue involves the following measures:

- (a) Avoiding many sexual partners,
- (b) Delaying sexual debut,
- (c) Condom use, and
- (d) Avoiding the cultural practice, including practices such as those involving sexual performance in the form of rituals.

Both PEPFAR's and Dondo and Maringue's approach on prevention are halfway in promoting moral values, as their approach on the use of condom serves sex practices, include sexual practices that fall outside the scope of moral sexual relationships.

It is clear that prevention means interventions, treatment and care which are to be implemented to reduce the impact of the disease through biological, behavioural, environmental, immunological, nutritional, and spiritual and social services. In general, prevention was first developed in the field of public health and epidemiology. In the context of this study, the concept of prevention has different meanings and functions. Prevention is declared successful if the knowledge of its causation; the dynamics of transmission, identification of risk factors and the continuous evaluation of development are applied as procedures. Any individual's behaviour is embedded on factors like the environment, including geographical space of living and communities around the individual; available structures; cultural factors such as norms; the meanings of behaviours and perceptions; economic and social resources including

health and education services. These factors are crucial for the success of prevention. Prevention measures are the premises that should take into account the perception of the people on HIV/AIDS prevention interventions.

Nevertheless, prevention should mean more than the spreading of information. According to Tara Das (2009), prevention should also mean changing behaviour of those who promote changes since they also have their own prejudices which are reinforced by the adoption of western biomedical ideology towards of HIV prevention in local settings.

In Dondo and Maringue people mentioned the existing contradictions among the HIV/AIDS activists, because of the manner in which they behave in nightclubs and the ‘*barracas*’. The activists were said to have failed to practice what they preach; because they ignore their knowledge about the biomedical approach on HIV/AIDS, and decide to behave against their knowledge. The issue of ignorance is demonstrated in Susser (2009). Mkhize (2009, in Susser (2009)), argues that people in Kwa-Zulu-Natal in Durban, South Africa blame their illness on being bewitched because of ignorance and denial. It is true that people blame witchcraft, but the interpretation of this situation differ to that of Dondo and Maringue, as illness is associated with *mbepho*⁵ and other bad spirits.

⁵ *Mbepho* is a Sena word, meaning a spirit that is sent by the ancestor to come and restore or correct behaviour among the people. This spirit come in the form of evil, because it causes bad luck that result in sickness, misfortune, death and other related problems. When people experience these problems in their lifetime, they consult with healers in order to check or determine the origin of their problems.

Ignorance is a relevant concept to analyse the behaviour around the HIV/AIDS prevention measure, as it was in the above related to the theory of resistance. In this study ignorance is discussed as the opposition to knowledge, which could be the rejection of knowledge or the lack of knowledge or information of a particular subject or fact (Thompson 1997). Kerwin (1993:174) argues that "the greatest achievement of science is the discovery that we know very little about nature and understand even less". The same applies to this study; ignorance refers to both the lack of knowledge about prevention intervention strategies and the rejection of/or resistance against these prevention interventions strategies. However, the findings from this study showed that people were not just being ignorant as they are portrayed, because they were able to define the concepts of HIV/AIDS using a biomedical approach, but also use local cultural concepts such as *xirombo* and *phiringaniso*. The ability to define the concepts from different cultural contexts shows that people are well-informed about HIV/AIDS. Their persistence in using of local concept is, from the biomedical context, ignorance to and a resistance of the biomedical approach.

The Community as a Social-Relations Organisation

It is necessary in this thesis to define the concept of community in order to understand how people of the same community share culture. In this study community means a form of social organisation that characterises the interaction between people in order to relate to each other. Community encourages a feeling of belonging. People have responsibilities and obligations to fulfil in their respective communities. The fact that people of the same community share culture, they tend to have distinctive

characteristics that relates to the culture of that particular community (Ife 1995). Despite sharing the same culture, there are huge diversities among communities. Awusabo-Asare (1999) provides two broad categories of community that are:

- (a) Vertical: referring to the groups with common interest, such as homosexual groups, religious group and ethnic-based group; and
- (b) Horizontal: referring to the group of people in the same geographically defined area. Sharing a geographically defined area does not necessary mean that people have common interests.

However, the public health model view these people as sharing the same culture, and, therefore, horizontally applied the biomedical approach. This approach does not take into consideration diversity and local cultural issues among the people of Dondo and of Maringue. Dondo and Maringue are occupied by different people with different relations that are characterised by different cultural relations with similar and different interests. Despite these different interests, they all share a concern on the issue of HIV/AIDS. These people were, as a result of sharing a concern on HIV/AIDs disease, formulated and their own locally interpreted HIV/AIDS approach.

A Theoretical Perspective on Rituals

The study of rituals is not new. It has been applied in many theories and by a number of theorists representing different disciplines. In the context of anthropology, anthropologists such as Van Gennep 1909, Douglas 1984, Turner 1954; 1961; 1962a; 1962b, Delphin 1988, Gluckman 1954; 1958; 1968, Mead 1928, Rappaport 1968,

Geertz 1973 and Bell 1997 discussed the meaning of ritual as the manner in which people view the world, including different interpretations and meanings of actions in different places. Rituals are said to be responsible for the manner in which individuals construct the meaning of their behaviour. A philosophy about that is integrated into the social context through rituals. Theorists from other social science disciplines, apart from special anthropology, have, however, studied rituals in different societies in the world and provided a broad version, understanding and perception of rituals. Rituals can be understood from historical, political, social and cultural perspectives. They are defined as a form of negotiation of social and cultural differences (Bell 1997). Rituals are part of human beings because they are meaningful actions performed by the people. These are ceremonies that go along major events such as birth, death marriage, marking a person's transition from one stage of social life to another. The meanings of rituals can be gathered as data that can test the origin of religions and civilization. Rituals are perceived as a form of communication that transmits the cognitive categories and dispositions that provide people with their sense of reality. They provide people with a way of structuring and interpreting their world. In this way rituals are interpretive tools that at the same time work to correct behaviour of people who tends to act against their traditional norms or offend the wish of the ancestors. Anthropologists have given rituals much attention. Many have been influenced by the work of Van Gennep (1909) in his analysis of the rites of passage. Van Gennep argued that the initiation rituals provide a conceptual model which shapes the meaning of a ritual (Smith 1986:152). Van Gennep asserted that the people in the processes of being initiated are separated from everyday life and social relations incorporated in post-liminal phase in which they gain new statuses. This process of re-incorporation is called symbolic birth, because individuals biologically obtain identity which is not just

recognized by relatives, but also by the entire society from which the individual is born and socialized or enter into the next level or stage of life. However from the traditional perspective, this birth is still restricting to individual whose life is not yet submitted to the rituals that will introduce him/her to social life and thus, and after the initiation, the individual's personality is transformed. This is a physical and social separation from the society that is considered a rebirth, because an individual obtains a new name, personality and identity (Martinez 1989; Ngole 1997). The rituals take a form of incorporation because an individual crosses the ambiguous and marginal status to the situation of aggregation to social life, from which he/she reaches the adult status and becomes a member of the community with access to full right for opinion and action.

Initiation, Death, Birth and Family Planning Rituals in Dondo and Maringue

In general the importance and utility of rituals in Dondo and Maringue is not different to other social contexts. Studies from scholars such as Reis 1955, Martinez 1989, Ferreira 1958 and Junod 1944 are testimonies in revealing the content and validity of this perception. The initiation rituals have different phases such as:

- Pre-liminal: is the behaviour that a person performs before initiation rituals, and that behaviour becomes the responsibility of the person who socializes that particular person;
- Liminal: In the case where the person get initiated, that particular person get isolated and separated from the responsibilities of the person involved in socializing, and all the doings and the behaviour during the initiation rituals became the responsibilities of the godfather and godmother; and

- Post-liminal stage: is about all the actions that are taken by this person after the transition of the liminal stage. The behaviour after the liminal stage becomes the responsibility and the accountability of this particular child/individual.

Different rituals provide different values and these values are considered or viewed as cultural values, because they are embedded in the culture of the people. These include achievements, circumcision, rituals, tattoos, notion of corporal hygiene during menstrual period, taboos and abstinence. Although the whole process of cleansing, for example, in healing and purifications of sexual relations, the cleansing process becomes a way of permitting one to live a normal life after one has gone through a period of abstinence. This means that rituals are the transmission of testimony through acquisition of knowledge and they take different shapes depending on what is to be achieved. However the different cultural backgrounds in the country have different influence depending on the manner in which a particular ritual is interpreted. The issue of different meanings has been influenced by differences in evolution, naming, and the influence of cultural-linguistic, where performance on the rituals also took different shapes. A ritual is a process of legitimizing knowledge, information, behaviour and attitude of individuals into a social norm. Rituals are as a result reflecting the culture of the society and they are performed based on indigenous knowledge, as the legacy of the ancestors of that particular community.

Indigenous Knowledge: The Reference and the Tool of Cultural practice

The theory of indigenous knowledge is applicable among the people in Dondo and Maringue in dealing with health issues, including HIV/AIDS because their cultural

health practices are historical and based on knowledge inherited from their ancestors. The concept of indigenous knowledge has emerged to describe the knowledge of a group of local people to a given environment. Geertz (1996) narrates indigenous knowledge as a part of cultural knowledge. However, indigenous knowledge is generally less valued when compared with the western 'scientific' knowledge and as a result, the determination of development is based on western knowledge with a view of that indigenous knowledge has nothing to offer. Escobar (1995) argues that development approach relied on western knowledge and as a result, marginalised and disqualified the non-western knowledge. Western science and indigenous knowledge are represented as two different knowledge systems, where western science is not only viewed as superior, but also as systematic and objective, whereas indigenous knowledge is viewed as being characterised by closed or unsystematic and primitive processes that are associated with backwardness.

The failure to recognise the value of indigenous knowledge did not only result from the dominance of western ideology, but also from the failure to understand that all different kinds of knowledge are socially constructed, and that knowledge is valued as a practical guide to the thinking around the creation of culture that is a guide to life. The determination of what is a valuable knowledge and what is just a knowledge started from the evolution of conceptualising the term knowledge that was built from the work on epistemology. Epistemology was the branch of philosophy that was concerned with the inquiry of knowledge and issues around knowledge including the sources of knowledge. It is clear that the biomedical approach was recognised and became advantageous in dominating non-western approaches in the health sector, and this is evident through the manner in which knowledge about health and related issues

are acquired. To continue neglecting non-western based knowledge is a failure to understand a particular knowledge about the culture and its cultural practices, whether western-based or non-western based, is valued because it is enabling towards an understanding on how one becomes knowledgeable that is compatible for a particular situation.

The concept of indigenous knowledge is associated with the term native, which often derogatory connotations (Smith 1986:148). Indigenous knowledge relates to cultural determination, the preservation and crossing of all established limits and the construction of boundaries that both separate and attach people in an innumerable of traditions and behaviours. Knowledge can be viewed as a basic mental category, by which people organise their world (Durkheim 1968). It is tied to the theory of ideology and the foundation of that particular knowledge in the context of grasping its origin. It is argued that the content of knowledge depends upon social or economic position.

CHAPTER III: METHODOLOGY

Activist A: Is she a doctor?

Activist B: If she was a doctor, she would not have come walking, but driving a car.

Activist C: and particularly a four-wheel drive, not just an ordinary car.

Activist B: Hey, you women you always like to be leading...I think she is lying.

Activist A: Of course she is lying. A doctor, wearing sandals?

Activist B: How would you look professional, while wearing cheap clothes?

None of her clothes qualify the status she claims to have.

Activist C: We will find out who she is very soon.

Activist B: Surely we will

Activists A: No, we do not need to find out, there is no doctor who would like to walk around in villages. Doctors are in hospitals waiting for patients.

Activist C: She might not be a doctor, but someone who was sent to come and spy on us. We just need to be careful when talking to her.

Activist A: If she is truly a doctor, she is then a simple doctor.

Activist C: May be, we do not know.

Teresa (presented here as Activist C) informed me about this conversation about my status (2007).

This conversation was a speculation between Teresa and her two colleagues about my status. Teresa was working as a volunteer in one of the Home-Based Care

organisations and became my fieldwork assistant. I accessed Dondo communities through the local government public administration that gave me permission to research in Dondo. I created networks with the community of Dondo through the Dondo Hospital. The director of Dondo Hospital suggested that I consult with one of the Home-Based Care Organisations for people living with AIDS in Dondo District.. Teresa was well known in Dondo. As a stranger, Teresa and her colleagues did not trust me and speculated about me, my status and my reason for visiting their communities. This distrust generated the conversation presented above. Teresa later confessed that she and her colleagues thought that I was lying, because nothing was available to confirm that I was a doctor, in terms of appearance. “Doctor” is a title given to anyone who has obtained a university degree in Mozambique. The manager of this home-based care organisation introduced me as a Doctor. The title appeared to have confused people, when they heard that I came to their area to research on HIV/AIDS, and assumed that I was a medical doctor.

People wanted to know who I was because they saw me as a stranger. Despite the confusion about the meaning of the title Doctor in that context, the issue of saying “Yeah, you women you always want to be leading” suggests that people still have difficulties in accepting that women can achieve in terms of education. Furthermore, the status of a person is determined by the appearance of a person and also what the person has. This means that these people would not have doubted my status, if I was wearing expensive clothes and driving an expensive car. The manner in which the person behaves also confirms the status, according to these people. They would not believe that a Doctor, even though they assumed that the title Doctor means a medical

doctor, could walk around the villages, because villages are low in status, and that doctors have better status and live in better places.

Although Dondo and Maringue are situated in Mozambique, as a researcher from Maputo conducting research in Dondo and Maringue I was a stranger. I was a stranger, not only because I was coming from Maputo, a place far from their places, but also because I spoke neither Shisena nor Shindau, the local languages spoken in Dondo and Maringue. I tried hard to be ‘one of the people’, but I was still a stranger according to them. I ate and enjoyed the local traditional food, tried to speak the local languages, especially when approaching them for the first time, but I was still a stranger to them. One of the members of Dondo community speculated about my membership in her community and said that my physical appearance and the manner in which I enjoyed local food, as she said that “She looks exactly like us and she seems to be enjoying eating matago⁶” but she could notice that I was not one of them. This woman further said that since I would be in the community for enough time, she will learn who I was.

My first experiences in the field were difficult and complicated because of the complexity in the use of ethnographic research methodology. It was difficult to introduce myself to and to gain trust from the targeted groups. This introduction was not just about saying my name, but getting to know them and to help them to know me in order to get their trust so that they would be open when they talk to me. I had to transform myself from being a stranger to being a native. Obtaining trust from the people was one of the techniques that I used in transforming myself into a member of

⁶ *Matago* is fresh rice that is grilled and pound. It is normally served as it is, without any additional condiments, or with milk.

these communities. But this transformation did not happen overnight. It was a process and a difficult experience, because it is not easy for a person to trust a stranger. People take time to know each other and there after, they happen to create good relationship and be open to each other.

The attitude of the people towards me, at the beginning, was not positive. I was informed by some members of the healers that they would only give information if tribute was paid to them, because people use information for commercial purposes. The money that is given to these people is not regarded as a bribe, but as a way of paying tribute to them. The fact that I was introduced to them as a doctor, could not mean that I was also a student and unemployed, and these people assumed that I had enough money and I should be paying tributes to them. During their process of narrating the norms of their communities on the issue of paying tributes, I explained that I had no money, because I was not employed, but I was just a student. It seemed as my explanation was doubted and as a result, these people did not give me a warm welcome and decided to give me 'a cold shoulder'. Over time the attitudes changed and many of the people started to be helpful.

I experienced difficulties because of the complexity of my research area as well. The drafting of my research question in the research proposal for this study was based on theories and completely different from the real world, in this case, the research field. I had visualised how to start collecting data, but my experiences disapproved my vision. My research topic was too multifaceted, because it involved not only the inquiry of HIV/AIDS prevention intervention strategies, but also the conflict of culture, including behaviours around intimacies, and other practices that are difficult for an outsider to

notice among these communities. As a result, it was difficult to start getting insights. I could not comprehend what was taking place in the field. I was not only an observer, but also a 'participant'. I became aware about the confusion in my head when I noticed the manner in which people were looking at me, and paying attention whenever I tried to speak to them. Their gestures could tell me that I was in a state of confusion. It was difficult to get a clear angle for saying-out all the issues concerning my study and how they related to each other.

My experiences in data collection were also a nightmare. I struggled to find a way to engage the participants. My worry was on the research field concerning the "home locations, bounded and integrated, rooting me in an imaginary past which contrasted sharply with the fragmentation of my present and the uncertainty of my future" Grimshaw (1999). It was a challenging experience that was added to the problem as Shore (1999: 29) states that in order to "convince readers that I was really there and faithfully got the native's point of view" I had to understand the environment, the people and the culture of that particular area. It was, therefore, necessary to live close to and even to live together with the research participants in order to obtain close to the insider perspective.

The experience in the use of ethnographic research methodology felt similar to everyday experience. It did not matter whether one is a stranger or a member of society under research. Before getting into the field, I had a feeling that things would be smooth, because Dondo and Maringue are also part of Mozambique. The matter of 'home-ground advantage' did not take place. I was just in a world different from my home. The language also made it difficult for me to get clues about the environment of

the communities, but the presence of Teresa as interpreter made it possible for me to understand the narratives from the participants. Without an interpreter, this language gap would have prevented me from getting clues on the issues of HIV prevention interventions and how they relate to the local cultural practices including ritual performance for health issues. Teresa was not always present however. In her absence I used Portuguese to communicate, but the situation did not favour me because not everyone in Dondo and Maringue spoke Portuguese. It was therefore, difficult to understand the meanings of each experience in the absence of an interpreter.

My first personal experience in the field work in this study was when I got into a taxi from Beira International Airport to Beira town in the evening of 28 March 2007. I spent a night in one of the hotels in Beira. I only spent a night because I was heading to Dondo and Maringue, which were my destinations as study sites. I planned to spend 45 days in Dondo and 45 days in Maringue. However, there were some interruptions because of my health. Before leaving Maputo a medical doctor I had consulted instructed that I had to go back for further check up at a date during the course of my field work. I had to go back to Maputo for medical consultation which meant putting on hold my research for about 15 days. I returned to the field at the end of May 2007, and moved directly to Maringue.

In the morning of 29 March I left the hotel in Beira for Dondo, driven by Carlitos. Carlitos was a taxi owner and a driver who served people around Beira and from Beira to other place around Sofala Province. I got his cellular phone numbers from the hotel reception. During our journey to Dondo, we introduced each other. I told Carlitos that I had never been to Dondo and that I have no idea on what type of a place Dondo was. I

asked him if he could help me find the place and also a place I could stay for more than a month. I was lucky to be driven by a person like Carlitos, because he knew Dondo very well. He also warned me that most places available in Dondo were expensive. He advised me to book at Orlanda and Beneth guest house and was surprised to know that he was well-known there. When we entered Orlanda and Beneth Guest House, the receptionists were shouting Carlitos' name and one of the receptionists spoke to Carlitos as if he had already booked a place for the two of us as she said your Room 3 is available, referring to both Carlitos and myself. This was a shock for me; I could not understand why these receptionists assumed that Carlitos and I had to share a room. Obviously these receptionists assumed that we were a couple. They did not know that Carlitos was providing me transport service only.

However, later in the evening I understood the picture that I had failed to read during the course of booking in Orlanda and Beneth Guest House. I found out that Orlanda and Beneth Guest House was a favourite spot for secret lovers, and Carlitos was well known in this guest house. After settling in my room, I asked for the district administration's location. As a newcomer in the area, I had to present myself before the local authorities as the culture was in the area. This is an honouring system to the local authority and a way of accessing and obtaining permission to be in the area.

I left the guest house and went to the local authority to present myself. It was a common procedure to speak to the local authority. I had to make an appointment to see the local authority, and I was lucky because a slot of time was immediately made available for me to see the District Administrator. On my arrival, I was greeted with the following words:

“I’m happy [...] because we need help to assist in explaining why HIV/AIDS prevalence is so high among our people. According to official statistics the prevalence is at around 36%. [And] we are very concerned with this situation. We are aware that local culture is contributing to the spread of HIV/AIDS, we hope you will make these people understand the negative impact of local cultural practices; your presence is welcome”

The Local Authority welcomed my presence, with the hope that I would provide answers to the continued spread of HIV/AIDS among the people of Dondo, which is a serious concern to the Local Authority. The Local Authority was able to tell the rates of the number of people infected by HIV/AIDS locally. The Local Authority was not just concerned about the issue, but also worried about the cultural practices, assumed to contribute to the spread of HIV/AIDS.

The meeting with the Local Authority lasted half an hour. Other than discussing HIV/AIDS, we spoke about the good work that Eduardo Mondlane University was doing in allowing students to conduct research. According to the Local Authority, I was not the first student to conduct a research in the village. He noted that a number of students had come to Dondo for research, and their work contribute in assisting the people by helping them change their lifestyles, while research results published in papers daily, help Authorities make informed decisions about their people.

I started my fieldwork on the last day of March 2007. I was in the research area for a period of three months during 2007. I went back to the research field at the middle of

2008 and spent about three months, and spent another three months during the last months of 2008. My fieldwork took a period of 7 months, which also included the time taken for data validation. In this way my fieldwork was a process involving different research participants in the study area, but also testing emerging issues. This study offered an understanding of social, cultural and religious practices in the context of HIV/AIDS in Dondo and Maringue communities. It also involved understanding the symbolic socio-cultural and religious practices such as *xirombo*, *phiringaniso*, *kupitakufa*, *kupitamoto* and *kuphitamabzwade* and possible impact of these practices on HIV/AIDS, including their prevention intervention strategies. In order to critically understand and assess the impact on these practices on HIV/AIDS prevention interventions, I related these practices to the general culture of the society. This approach assisted towards understanding how the wider social, cultural and religious practices impact the HIV/AIDS prevention interventions strategy.

The background knowledge and the method of validating are ingrained in ethnography, the major research methodology in this study. Ethnography is an anthropological research methodology that is characterized by study of a small community or ethnic group (Smith 1998:98). It is the hallmark of traditional anthropology (Spradely 1979b) involving spending a long period of time in the communities. Ethnography is an approach used in learning the social and the cultural life of communities, institutions and other settings that are both scientific and investigative (Le Compte and Schunsul 1999). It allows researchers to be the primary tool of data collection and rigorous research methods and data collections techniques to avoid bias and ensure accuracy of data (Walraven et al. 1996). Ethnography was a means in providing empirical information and a master tool in analyzing research data. The use of ethnography was

about capturing what the people of *Dondo* and *Maringue* thought about HIV/AIDS. The aim was to understand how the people of Dondo and Maringue interpreted HIV/AIDS, their concerns on HIV/AIDS and their actions and behaviour associated to these concerns. These actions and behaviour included social, cultural and religious practices which may contribute to the spread of HIV/AIDS. This ethnographic study did not only concentrate on HIV/AIDS, but also on the contextual environment of the study communities. I assessed the environment of these communities in order to understand the culture influencing the lifestyles in Dondo and Maringue. I also assessed the cultural practices as well as how these cultures relate to each other, including how these cultures influence lifestyles of these people.

I selected ethnography as the research methodology for a number of reasons. Firstly, the reflexive nature of ethnography helps in building a rapport with research participants as well as the application of different research strategies for evaluating and validating different sources. Secondly, I aimed at using the interpretative analysis that was a tool in the representation of knowledge that describes culture (Van Maanen 1988). It was mentioned above that this study did not only concentrate on HIV/AIDS, but also on the culture that influences the behaviour of people. This research was thus conducted in the context of understanding representations of cultural dynamics, motivations of sexual behaviour, perceptions, attitudes, beliefs, feelings and emotions in the context of HIV/AIDS, including its prevention intervention strategies. According to Weber (1922: 87) the interpretation and analysis of data should be built from the context “of the social reality”. ‘Subjective interpretation’ approach was used as data collection and analysis and this created an advantageous situation to assess the cognitive behaviour of social actors.

In order to understand the conflict between the prevention messages disseminated and the meanings of sex, sexuality and HIV/AIDS, the narratives from the people of Dondo and Maringue became the medium for the construction of the meaning of the practices—ethno-methodology. In pursuing how people of Dondo and Maringue marked the relationship between the symbolic and the meaning of the practices, I explored the underlying symbolic systems of the structure of the phrases during their story telling. I learned that “*xirombo*”, for example, was a local concept meaning a virus, and also means HIV. Meanwhile AIDS was called “*phiringaniso*”. *Phiringaniso* was locally defined as a disease that emanated from *xirombo*. Tuberculosis (TB) was also defined as *phiringaniso*. I also learned that a certain ritual, i.e., *kupitakufa* was performed among these people in relation to the prevention of HIV (*xirombo*) and AIDS (*phiringaniso*). This included rituals such as *kupitakufa* – a ritual for cleansing, *kupitamabzwade* –post-luminal ritual, and *kupitamoto* - cleansing ritual after a house in the homestead is burnt. These rituals were used “symbolically” to explain the story behind people’s daily practices and experiences. However, these concepts and rituals are discussed in detail in chapter VII of this thesis. The myths about HIV/AIDS strategies were socially and symbolically constructed in studying communities and were enabled through the narratives of the current and the past practices. Although HIV/AIDS prevention interventions and programmes were dominating, local concepts and rituals were used symbolically in communicating about health issues including HIV/AIDS, but were not adopted in the public health practice. The use of the local cultural practice around HIV/AIDS became an ‘informal’ means of prevention that could be understood as rational norms, values and beliefs. The use of these concepts and rituals became a challenge to the manner in which people make decisions

concerning health including on HIV/AIDS and its prevention intervention strategies. For example, *kupitakufa* ritual was performed as a fundamental building block in social, cultural and religious practices and as a response to HIV/AIDS. All these cultural practices were socially and culturally constructed and rooted in indigenous knowledge, and were becoming processes in responding to HIV/AIDS reality.

Phiringaniso and *xirombo* are the major concepts in health among the local people, and *kupitakufa*, *kupitamabzwade*, *kupitamoto* and *xitonga* are the rituals that validate these two cultural concepts. My understanding of the relationship between these concepts and rituals was guiding during data collection. They were significant in pointing out how they relate to health issues including the biomedical HIV/AIDS intervention strategies. Although these concepts and rituals are still not recognized and not used in the context of biomedical HIV and AIDS prevention interventions, their existence proposes new theories, concepts, and methods of enquiry in HIV/AIDS interventions. What is important in this context is to understand the underlying nature of symbolic practices of the concepts and rituals, and how these rituals and practice relates to the cultural backgrounds of the local people and their understanding, and how they impact the biomedical HIV/AIDS prevention interventions.

Research Participants and Data Collection Methods

There were a number of actors I met during fieldwork, including NGOs, health professional and administrators, teachers, youth, individual members of the communities, traditional and community leaders including traditional leaders religious groups and people living with AIDS. I used a self-generated data technique in schools

where I requested the students to ask questions about sex and sexuality and HIV/AIDS. In order to guarantee anonymity and thus to encourage students to express their concern freely, I asked them to write down only their questions and not their names, but to include gender, age and school class level. The purpose of using this technique was to allow youth to ask questions about their concerns in order to determine their knowledge of the spread of HIV/AIDS. The self generated data technique was considered advantageous because the students were free to express themselves and ask question in the cover of anonymity. Anonymity encourages people to give answers that are less suspicious and almost certainly more precise than respondents who think they can be recognized (Kleinknecht et al. 1986; Fuller 1974; Stone et al. 1977; Tracy and Fox 1981; Wiseman et al. 1975/76). The practical and ethical considerations within methodology required questionnaires that allowed anonymity.

A distinction was made in this context, between questions which are self generated by the students and those initiated by the researcher. The imposed inquiries included formal and informal situations and experiences that youth have in their daily lives. In this case young people were free to ask any kind of question without any influence from the outsider. The method provided an opportunity to get information, which as a researcher I may not have thought of, although I was responsible for formulating questionnaires. Self-generated data was an exploratory research technique that played the role of gathering information from people who were a source of information. In this technique the researcher plays the role of imposer and participants as agents are asked to respond (Gross 1995). I used the imposed inquiry model and the self-generated data from the youth was useful in getting the cultural background of the people in research sites and to construct relevant questions in the interview guideline for others

participants including community leaders, parents, teachers, people living with AIDS and NGOs.

I requested the headmasters of the schools involved to organise the exercise with the students and group discussions with teachers. The discussions with teachers revolved around HIV/AIDS, sex and sexuality in order to teachers perceptions on AIDS prevention interventions. The used research process or self-generated data method has been used in studies in Kenya (Ahlberg 2001) and Zimbabwe (Chikovore 2002). In these studies, questions provided an important tool for reflecting with other community groups, such as parents, teachers, healthcare workers, religious leaders and traditional leaders, traditional and faith healers and people living with AIDS (PLWHA).

Focus Group Discussions were important in this study because, as Stewart and Shamdasani (1990: 15) argue, they assist in obtaining general background information about a topic of interest—in this case, HIV/AIDS prevention intervention strategies. This generated and stimulated new ideas; diagnosed problems that required a review on the current HIV/AIDS prevention intervention strategies and provided a learning curve on how participants interpret HIV/AIDS. In other words the advantage is that the participants in debates provided in these arenas (group discussions) were an interaction among people with different views. Participants could question each other, agree, and disagree on issues and generate debates on different issues around their communities. During the discussions, I also learned that people did not equally obtain information; some were well informed on specific issues while some had no clue on what was going on in particular issues.

Semi-structured formal and informal interviews were also used in collecting data from the key informants. The objective of using semi-structured interviews was to make the environment enabling in terms of “thick description” (Geertz 1973: 5–6). In this study, semi-structured interviews were based on key informants. The key informants included people whose positions were central in accessing information related to local health and cultural issues; for example, community leaders, administrators, health professionals, representatives of NGOs, donors in HIV/AIDS programs, representatives of secondary schools, widows and people living with AIDS. Drever (1995) says that “semi-structured interviews are flexible techniques for small-scale research”, and suitable for studies involving small numbers of people including key informants and case studies. The interview guides were elaborated from the questions and concerns expressed by young people in schools as a way of getting the community perspectives on those concerns.

Other than self-generated data, group discussion, and semi-structured intervention, participant observation was used in this study extensively. This technique enables researchers to generate data from research participants in the natural world and to have a broad perceptive on the ways the participants live in their environment (Neuman 1999). I used participant observation during data collection especially on schools and home-based-care organisation. As a participant observer I immersed myself in local life situations in order to understand how things work (Rennie et al. 1995) in matters associated with sex and sexual relations, and the meanings and perceptions of research participants on HIV/AIDS and prevention interventions. My personal presence in their daily activities, as “participant observer” has thus provided me with the opportunity to learn their daily experiences including getting to understand their values, dynamics,

relationships, structures and conflicts through observation, rather than from statements by the research participants.

Sampling

I used a number of strategies to identify the research participants. Snowball sampling method was employed to select the target groups that could better inform on HIV and AIDS prevention interventions, as well as cultural practices that affect the prevention intervention strategies. Snowball sampling is also known as network, chain referral, or reputational sampling (Neuman 1999).

I started with four secondary schools, where I identified how these schools were linked to community leaders, healers, health centres, NGOs and PLWAIDS, parents and other related structure of the society. I accessed the schools through the school administration. These schools became the central point or the ego-centre of identifying the network of the structure in the communities that did not only have information about what was going on in their societies, but also how they relate to other structures of the society. The egocentric network from the youth, particularly those who were students is presented in Figure 6.

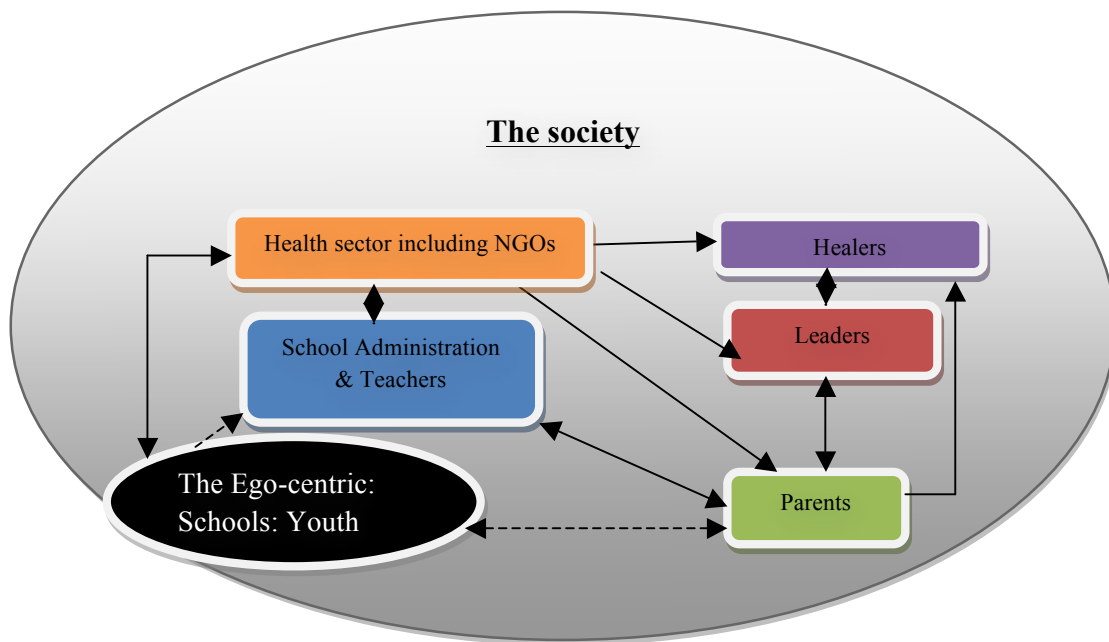


Figure 6: Ego-centric: identifying sources of information from youth to other informants

To get access to the students I asked the headmasters in each school to organise meetings with students, teachers and parents. The community leaders were identified with the help of the president of Municipality in the case of Dondo and with District Administrator and the Position administrator in case of Maringue; while healers in each District were identified through the Association of African Medical Doctors president in each District (AMETRAMO).

Research Field: Culture

A total number of 352 students from different schools and grades, ranging from 13 to 22 years old were involved in the self generated data. Interestingly, only 118 girls participated against 234 boys. The problem is that among these communities, boys are

the majority in schools. Girls drop from schools at an early age because it is the common practice in these societies to have a girl attend school only till she can read and write. Attending school up to this level is to prepare them for marriage. They must know how to read and write in order to communicate with their husbands who leave their homes and families behind for working in cities far away from their homes. In the context of a focus group discussions technique, about 10 groups, each consisted of about 8 to 12 participants, including various types of leaders (mainly community leaders, religious, healers, professional groups, healthcare providers and people living with AIDS), as well as men and women in the community. Semi-structured interviews were conducted with about 31 key informants among groups listed above. The purpose was to collect and validate data in terms of concepts and other related concerns.

For the purpose of analysis, an interpretive approach was used to incorporate the opinions from different participants in the study, and to understand the meaning of these opinions. It was necessary, as Neuman (1985:71) argues, to “study the meaningful social action”. The objective was to understand the meaning of the socio-cultural practices and their impact on the spread of HIV/AIDS.

Participant observation was fundamental in understanding people’s everyday life and how they interact (Neuman 1999:71). It was necessary to take into account the ideographic and inductive in order to provide a symbolic representation and thick description of the reality of Dondo and Maringue. In interpreting the meaning of the languages on HIV/AIDS intervention strategies, I compared the local cultural health practices and their strategies with the biomedical approach to HIV/AIDS prevention intervention strategies.

Students asked questions around sex, and sexuality in the context of HIV/AIDS. Their questions later became crucial for/in the whole research process. The questions helped me to ask questions about the cultural background and the social reality of the different structures of the society, all from the manner in which the students expressed their concerns on issue of sex, sexuality and HIV/AIDS in their daily lives. Some of their concerns were the sources of information about HIV/AIDS. Their questions, expressed that the students learned about HIV/AIDS from different sources. They receive information on HIV/AIDS from the formally recognized institutions in the society such as hospitals, clinics, NGOs, etc, and the informally recognized institution such as parents, traditional leaders, peers, etc. This situation is conflicting because information about AIDS is from different sources with different approaches. For example, the youth get information from schools and government health institutions that are based on biomedical approach and also from parents whose information may be based on the biomedical and/ or local cultural practices. This also includes information that came as rumours to the community.

Findings suggest that the students were able to explain the relation between HIV/AIDS and the local cultural practices. This relate to getting infected with HIV as a result of performing rituals, the myth around the use of condom on the basis that condoms were believed to be transmitting HIV; lack or little concern with HIV/AIDS on the belief that HIV/AIDS does not exist; and the relationship between the meaning of HIV/AIDS with traditional diseases such as *xirombo* and *phiringaniso* and so on. All the issues raised in questions by students enabled me to create semi-structured interviews for

different social actors and research participants. Some of the questions that students asked are presented below as follows:

Questions and Reflection for Different Participants

1. What is not being done, said, and understood?
2. What and where are the gaps, the misunderstanding, wrong ideas, issues unknown to people, new problems?

Questions and reflection with student parents

1. What do young people learn at home (also what do parents think about what children learn in schools, churches, public, and media in relation to HIV prevention?
2. What issues are addressed in education (what is not addressed?) in relation to HIV and AIDS?
3. What has been said about HIV/AIDS prevention interventions?
4. Do parents discuss sex and sexuality with their children, including HIV/AIDS? If yes, how and what issues of sex and sexuality are discussed, and not addressed?
5. What kind of education is given to girls (ritual initiation and so on)?
6. What parents say about sex and sexuality to girls and boys?
7. Under what context do parents raise these issues?
8. Who talks about what?
9. What is done in relation to children, and do children have similar opportunities?
10. What do schools say about sex, sexuality in the context of HIV/AIDS and prevention and interventions?
11. What type of questions do children ask on the following issues: menstruation, love, feelings, masturbation, homosexuality, and how do people address these issues?

Verify the HIV/AIDS policy in the education sector

1. What does HIV/AIDS policy reflect?
2. How do you identify organizations that work with youth and what are the messages they transmit?
3. What do other organizations say about the policy?
4. What kind of education is provided to people concerning HIV/AIDS?
5. Is the HIV/AIDS policy effective?
6. What are the problems with the use of condoms?
7. Is there any discussion about the meaning of sex and sexuality?

Preliminary results: questions and reflections with teachers

1. What is the impact of media in terms to the way women are presented on TV?
2. What are the teachers' points of view on women?
3. What are the teachers' perceptions on HIV/AIDS prevention interventions?
4. How do teachers prepare student to face HIV and AIDS?
5. What is currently done to address the problem?
6. What was done in the past?
7. What kinds of programmes are available to address moral behaviour, and how do these programmes influence the behaviour of the students?
8. What kind of skills do the teachers have in communicating about the issues of HIV/AIDS?
9. What dilemmas normally occur?
10. What type of questions do teachers have?

Question and reflections with health professionals on HIV/AIDS prevention interventions

1. Do they have HIV/AIDS prevention intervention programmes?
2. Are there any changes since the implementation of these programmes?
3. How do changes come about? Or what are the measures of these changes?
4. What has been done since the arrival of NGOs in their communities?
5. What do the NGOs provide and how?
6. What kind of limitations do they face in achieving their objectives?
7. What information is available about medicine at hospitals?
8. How do they serve the people?
9. What information do healers have regarding treatment?

Questions and reflections in the role of Government and NGOs

1. What is the relationship between government-health sector and NGOs?
2. What is that the government does to address problems?
3. What is the nature of interventions?
4. Do they experience the issue of stigma and how do they address the problem?
5. What are types of treatments available and what are the issues around these treatments?
6. How do patients and the public perceive these treatments?
7. Is there any communication between medical doctors, healers and patients?

Questions and reflection with People living with HIV and AIDS (mainly spouses of deceased)

1. Do they follow the traditions and practices to understand the current existing cultural practices?
2. What are their experiences in relation to the disease?
3. What is their relation with hospitals?
4. What are their experiences in terms of medication?
5. What is their relation with counselling?
6. What treatment and the type of information did they receive?
7. What kind of rights do they have and what is that they are allowed to do and not to do?
8. What are their opinions on the following structures of the society: churches, healers, herbalists?
9. What are the other types of traditional healing available?

Question and reflections with the government regulations and the National Council against HIV/AIDS

1. What is the purpose of the national HIV/AIDS policy?
2. What are the plans implemented in terms of translating the policy?
3. Are the objectives of this policy/strategies/plan being met?
4. What are the problems experienced as identified in the quarterly, bi-annual and annual review of the strategies/plan?
5. Do they review the donors' policies in relation to financial management?

Conducting research is always a matter of strategy. Problems in accessing participants arose during my fieldwork, because I was dealing with people who were too busy with their daily plans and tasks to fulfil my demands. I had difficulties in accessing some of

the participants, especially the key informants. This became a concern during the fieldwork, because in most cases, these people were too busy to give me the attention I needed as a researcher. As a result, I did not have enough time to spend with them. The experience called for creativity not only in generating data, but also in time management. This fieldwork took two phases where the second phase was the use of participant observation, semi-structured interviews and focus group discussions. The question on how to use these techniques arose and I thus came up with the first phase which was preliminary gathering information through focus group discussions and interviews with teachers, parents, community leaders, NGOs, PLWA and participant observation.

Strategically, I promised the participants to provide feedback of the issues discussed especially on issues discussed with teachers and students. I brought back the preliminary results and discussed with these participants. The purpose of bringing in the preliminary result was to allow people to confirm if the issues noted in the preliminary results were what they said during the group discussion, including the meanings of the issues discussed. Methodologically this was a necessary strategy for obtaining confirmations from the claims, and to generate more arguments, building on from their claims. The following boxes present some of the preliminary findings collected during group discussions. Box 1 presents some conclusions in the analysis from student questions. Concerns that students raised are presents in Box 3. Box 2 presents some conclusions indentified from the perceptions on HIV/AIDS including prevention interventions in the context of sex and sexuality.

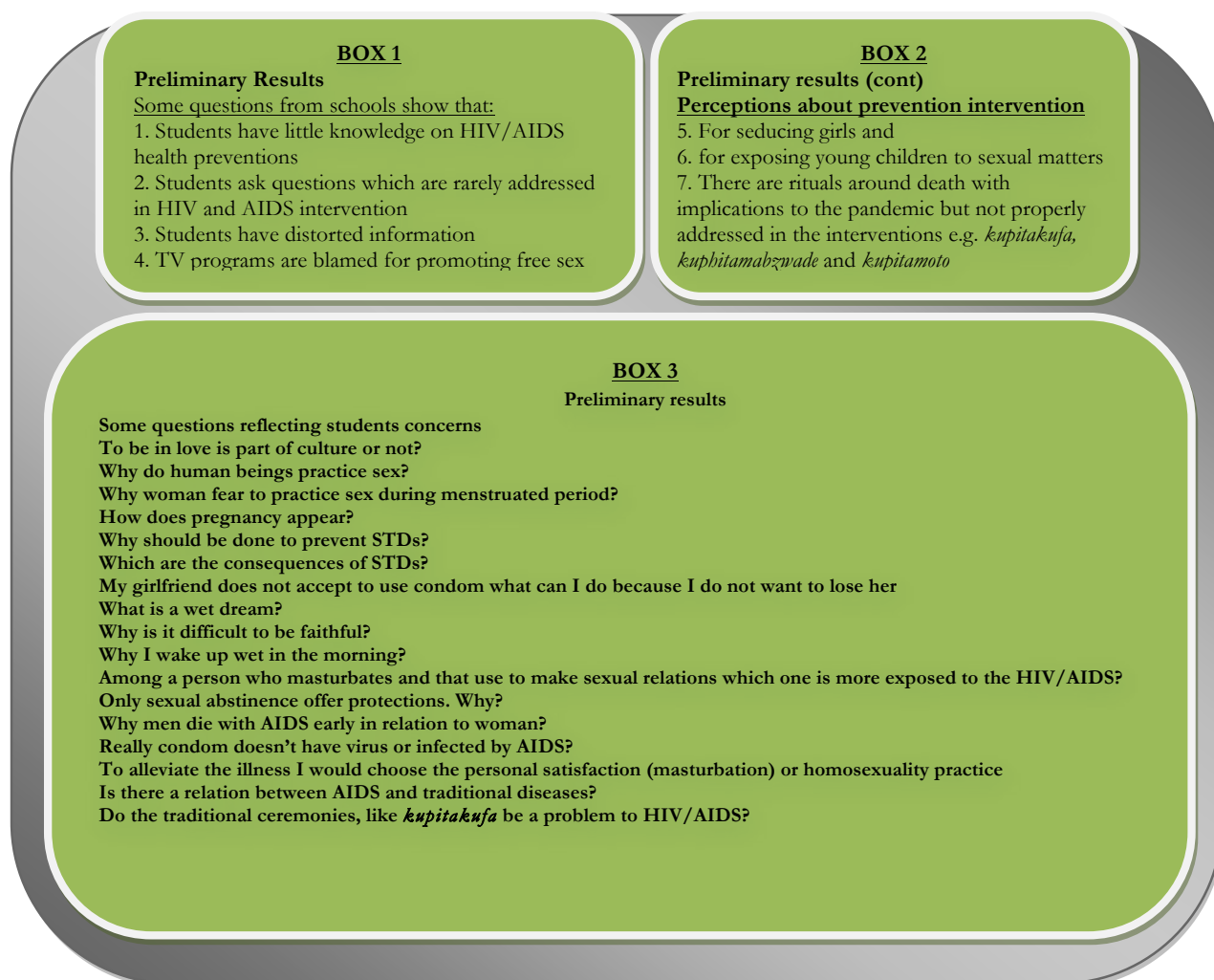


Figure 7: Boxes representing some research preliminary results

The preliminary findings were used and became the base for understanding the socio-cultural factors determining basic aspects of sexual behaviours in relation to HIV/AIDS. Culture shapes individual sexuality through roles, norms and attitudes (Carbanell et al. 1999) but culture also contributes to the collectivist cohesion of communities through their rituals and practices. I used preliminary results as strategy to transform the research data gathering as a dynamic and interactive process, by provoking different group discussion through presentation of some of their concerns, statements, and earlier thought by the participants during the first phase of data

collection. Some of these groups included people with different points of view, and this was advantageous, because apart from interaction among the members of the group discussion, the arena provided people with the opportunities to debate, agree and disagree on different subjects. This provided me, with an opportunity to explore more questions that needed to be addressed. I was able to understand that, although people recognise and acknowledge the biomedical interpretation of HIV/AIDS, including their prevention intervention strategies, they also still use their local knowledge, based on indigenous knowledge. People continue with the local knowledge because they believe the protective role of ancestors as entities, despite the fear of *mbepho*, but mainly because this is their culture with norms of behaviour, meanings, values and codes of conduct that differentiate and give identities to people. However, discussions that were conducted in school help me to understand that people believe that diseases are the result of transgression of norms and taboos, and as a result rituals should be performed in order to correct the problems that are being experienced.

Strengths and Limitations of the Study

I chose Dondo and Maringue districts as my fieldwork sites to gather data on the spread of HIV in Mozambique. The reason for choosing these districts was their geographical position although they are situated in the same district. Dondo is a district situated in the development of Beira Corridor, while Maringue is a district in the inner part of the province which is quite marginalized from the efforts of development, including the distribution of basic resources. Maringue started to receive attention from health and education services in 1996. This was when the country started to generate and facilitate economic activities among these people. This study

concentrated on the socio-cultural aspects but did not overlook the economic and political aspects that affect the HIV/AIDS prevention interventions are being developed.

Efforts were made in order to conduct the research study in a consistent manner. Data from focus group and semi-structured interviews were accurately and honestly recorded and attendance registers were kept. Additionally home-based care visits were conducted in order to observe the HIV and AIDS prevention interventions; thus also to understand how communities perceive and interpret the meanings of the activities in dealing with the diseases, and HIV and AIDS in particular. As a researcher I recognized that the dynamics in each district were differently approached. I hoped that the findings of this study provide greater insights of actions around HIV and AIDS prevention. However, in the study area there has some limitations mainly related with the lack of accurate knowledge regarding the local language. So I had to use translators from amongst the local people, running the risk of not getting being able to convey the fundamental idea behind the posed questions. Distance from one location to other was a limitation mainly for the participant-observation technique, since in Maringue there was no public/private transportation. The data in the study reflect the subjective views of the research targeted stakeholders.

CHAPTER IV: AN OVERVIEW OF THE STUDY SITES

Mozambique is described as one of the poorest countries in the world. The inequality and inadequate distributions of the resources at the national and provincial level becomes worst at the district and community levels. The situation reflects the unequal development of the country and the poor lack access to basic needs. The problem is not only because of the economic status of the country. Rather, it is the lack of a proper system of providing basic needs. People have to, for example, walk for long distances to access services from localities that do not even fall under their district administrations.

This chapter describes the health-care system in Mozambique within which HIV prevention interventions take place, where the informal prevention practices occur, and how the HIV/AIDS prevention interventions and informal prevention interventions confront each other. According to this study, informal prevention interventions, referring to the local cultural practices against diseases including HIV/AIDS is a central issue in determining the effectiveness of the biomedical interpretation of HIV/AIDS, including its prevention interventions strategies. These informal preventions are still not formally recognised or even acknowledged by the policy makers around health and its related issues.

Narratives were a means of accessing information and the meanings of how people in their communities share indigenous knowledge (Iseke-Barnes 2003:217, 218;

Castelhano 2000: 31; 1999: 34–35; Lanigan 1994:103). A narrative is a story telling about something that is taking place or happening, including experiences around the event. It is the narration of the succession of functional events. Narratives relate to metaphors, because metaphors as Turner (1969:4) presents are the ways of proceeding from the known to the unknown. This is the means of effecting instantaneous fusion of two separated realm of experience into one illuminating, iconic, encapsulating image. Polanyi (1967) refers to metaphor as “tacit knowledge”, the presentations of stories in the form of metaphor. Local people use metaphorical stories to describe their past experiences. In order to understand or to make meaning of this metaphorical expressions and analogical reasoning approach for interpreting. According to Black (1962), analogical approach helps in interpreting informants’ analogical area to which the ideas are placed for analysis.

The narrative technique was used to describe the historical emergence of both Dondo and Maringue. Dondo and Maringue are discussed to highlight their historical and cultural environment, and thus contextual factors that influence the risk of HIV. The discussion include factors around inadequate social services, lack of public infrastructures, ineffective or lack of education around health, ineffective communication, people’s use of different languages, different perceptions that are determined by cultures, cultural practices, gender inequalities, ethnic, economic differences, lack of political will, and weak national-strategy on HIV prevention (Parker 2005:2).

The Healthcare System in Mozambique

Dondo and Maringue districts belong to the third tier in the structure of the country as presented in Figure 8. The fact that Dondo and Maringue are in the third tier in the structure of the country has significance in terms of access and availability of social resources including health facilities.

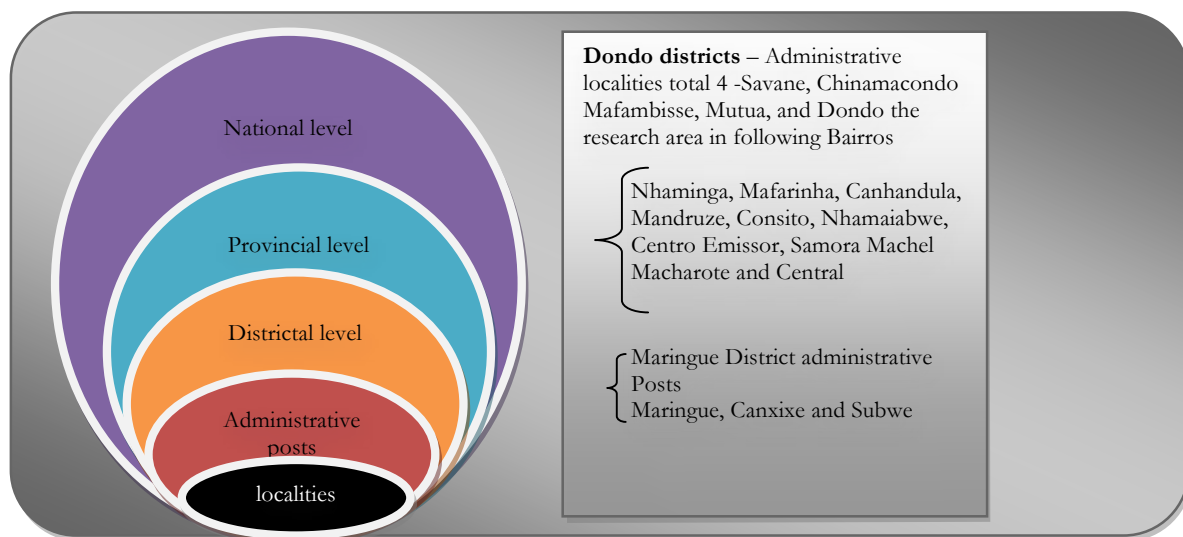


Figure 8: Mozambique: structure of the country

The healthcare system in Mozambique is administered by the “Ministério de Saúde” (MISAU) literally translated as Ministry of Health through hospitals, healthcare centres and health posts. The current financing policy is based on the principle that all Mozambicans should have access to quality care at an equitable price (UNDP 2002). There are 3 levels of organization—national, provincial and district level. At the national level Mozambique has 3 main Central hospitals which are located in the north, centre and south of the country; the biggest hospital, located in Maputo in the South, is the national referral hospital. The second is in Beira serving people in the central region and the third is based in Nampula serving people in the Northern region. The

lowest level of health care is provided by Health posts and there are the following types of health dispensing units:

- Healthcare Centres
- Rural Hospitals
- Provincial or General Hospitals

These different health-care centres provide different services and have different specialists. These centres serve rural areas differently from those in the cities. Both hospitals' and health centres' first port of calls are the *Banco de Socorros* (literally meaning Bank of Help). *Banco de Socorros* provide services similar to those in an emergency room, but due to the workload in the health centres and hospitals the tasks change. The problem is a shortage of medical resources and other health professionals in the whole country. Mozambique had about 700 doctors in 2004 (PLoS Med. 2007). The Central Hospital in Maputo had about 173 doctors serving about 7.6 million people (*Human Resources for Health* 2006). Resources are thus not equally allocated throughout the country, particularly between urban and rural populations and between the poor and rich. Due to the lack of resources and quality health services, people (in government, owners of private enterprises and the middle class) who can afford consult with hospitals and medical centres in South Africa, Portugal or other countries of their choice. The challenges that Mozambique faces with regard to affordability in terms of health issues include the following:

- 30–50% of the populations have access to basic preventive and curative health services;
- High level of communicable diseases: about 13% of adults living with HIV/AIDS, while there are 18,108 cases of malaria per 100,000 people (UNDP 2002).

The health ministry closed down Hospital Days (hospital day was a clinic for people who live with HIV/AIDS) which was operational from 2003–08 to serve people in Maputo, Gaza, Sofala, Manica, Tete, Zambézia, Nampula and Niassa. The reason for closing down Hospital Days, as the Health Ministry said, was that it was stigmatizing people with HIV/AIDS. As a result, people would automatically know that people who consult with Hospital Days are HIV positive or have AIDS. The centre became the “centre of HIV/AIDS patients’ discrimination”. The work that Hospital Days served, are now integrated into the general health system. ARVs are now directly accessed from the general pharmacies of public health hospitals and the people who are HIV positive are admitted in the general ward. However, according to associations that fight against discrimination of HIV positive people, people are badly treated in different hospitals of the country, and as a result some of these patients give up the treatment (Plus News January 2010). The decision to stop Hospital Day has worsened the situation by exacerbating the situation of inadequate resources and lack of health facilities for people with HIV/AIDS. Dondo and Maringue have poor social service delivery and lack of infrastructure as the following indicates:

- Shortage of staff (Chaos 2002) nationally; and
- The general lack of facilities such ambulances, including desks for medical equipment and medicines.

In such a context, the traditional doctors or *curandeiros*⁷ play an important role in providing health care to both rural and urban populations. A large number of the population do not have access to the public health service, as a result of which they consult *curandeiros* as their only source of health care.

⁷ *Curandeiro* is the Portuguese word for a healer.

The current healthcare system in Mozambique is a proof that HIV risk cannot only be viewed from the context of individual behaviour. Rather, it should be seen as a failure of government to provide health services to the people, including people with HIV/AIDS. Thus, to concentrate on people's behaviours as the condemning the increasing spread of HIV/AIDS is to ignore that people may not be doing this by choice, but because of the lack of resources.

Health Care in Dondo and Maringue

Dondo, which is presented in the annex A, map 1 it has an area of 2355Km² and 198.643 inhabitants, has only one general hospital, one health centre and four health clinics. Healthcare personnel include seven medical doctors, 28 health practitioners, 43 female elementary nurses, 18 midwives and 21 male elementary nurses. People in need of help, especially those with serious conditions, are normally assisted by the NGOs in the area as presented in Picture A.



Picture A: *Members an NGO assisting a sick person.*

Although NGOs are able to visit people with AIDS in their homes, the situation is not conducive for proper treatment. Many are poor, and their houses do not meet requirements to shelter a sick person as is clear from Picture B below.



Picture B: *A home of one of the person sick from AIDS in Dondo*

However, there are additional healthcare facilities, including four voluntary counselling and testing (VCT) facilities in the district, but resources are still scarce for meeting the health needs of the people. In Dondo, HIV/AIDS prevalence data were mainly collected from pregnant women and people with AIDS. Majority of healthcare facilities in the whole country target pregnant women.

However, some of my key informants argued that the majority of men, especially those who live in rural areas were in polygamous marriage, and the problem of people with multiple relationship country-wide have not received attention in government's health services. This challenge is linked to the national statistics on HIV prevalence released by the government. It is still uncertain the extent to which people with multiple

partners and those that practice polygamy have tested HIV positive or negative. The situation of HIV/AIDS in Dondo as of 2007 is presented in Table 1

Health services, woman and social action sector of health (Dondo District)				
	Year			Index
HIV/AIDS Disease		Tested people	HIV positive	HIV Prevalence
	2005	4.621	1.525	33%
	2006	5.387	1.968	36,5%
	Increasing	16.2	29.0	Info/N/A

Table1: *Health services, woman and social action sector of health: Data from ACNUR/PNUD*

Similar to other remote locations in Mozambique, access to healthcare facilities in Dondo and Maringue was determined by the distance between the areas of concern with the capital city that makes decisions on health issues. Maringue's access to health service was determined by the distance between Maringue and Beira where the public authorities are situated. Rural districts situated far from Beira have little access to the service. During 2007/8 Maringue district (see the map 2 in annex B) with a total population of 61,080 in a total area of 6290 km² had only two healthcare centres and two healthcare posts, and no medical doctors.

From 2000 to 2005 about 2987 people in Maringue were diagnosed with STIs (interview with the Counsellor, 2007). The first VCT facility started operating in Maringue in April 2007, twenty years after the first case of HIV was diagnosed in Mozambique. Between April and June 2007 out of 128 people tested at the voluntary testing and counselling clinics, 28 people tested HIV positive. These people were between 15 and 40 years of age. There was no ARV treatment in the district until June

2007, only a few organizations offering healthcare work in the district. These include Red Cross, Mozambican Traditional Healers Association (AMETRAMO) and Encontro Fraternal das Igrejas de Maringue (a religious organization in Maringue).

To see whether people were actually ‘resisting’ health prevention interventions aimed at reducing the spread of HIV and AIDS, I focused on the interventions in order to check if the approach recognised the socio-cultural issues. Statistical information suggests that the answer can be deceptive (See Table 2 and Table 3 below).

Item	Maringue	Canxixe	Súbue	Total
Healthcare facilities	2	2	2	6
Health personnel	19	2	3	24
People assisted/day (average)	50	18	13	81
Beds	25	7	4	36

Table 2: *Health care in Maringue*

Education level/category	2004	2005	2006	2007
Tertiary education	Info/N/A	Info/N/A	Info/N/A	Info/N/A
Grade 12	4	4	10	23
Grade 10	14	22	23	23
Grade 7	3	3	3	3
Accountants	1	1	1	1
Administration	1	1	1	1

Table 3: *Healthcare personnel by category*

Source: *Annual Administrative Report (2006)*

Ambulance service was, however, limited because only one was allocated per district to serve the entire district population, and the situation was made worse due to the shortage of petrol. Thus, the sick face serious problems in reaching the hospital or health centre. To access the healthcare centres, people use alternative transport like bicycles or ask for assistance from other members of the community who own cars.

Besides healthcare institutions, Dondo has only 48 primary schools and three secondary schools. In Maringue formal education has been available since 1996. The reason for this late access to formal education was due to the postcolonial war from 1977–96. There were about 46 schools in the district serving about 13,259 students—4626 female and 8633 male—assisted by 151 teachers—24 female and the rest male (Administrative report 2006). Some of the schools were built using low quality construction material, as a result of which many classrooms collapsed during the storms and rainy season. There was a high percentage of school drop-out, a major reasons being the long-distances, many have to travel to schools. Many of students walk for more than 20 kilometres a day to and from schools.

Dondo and Maringue Districts in Sofala Province

The City of Dondo has three administrative posts and one municipality. It has five administrative posts at the local level, namely, Savane, Chinamacondo Mafambisse, Mutua and Dondo. The district had the following district neighbourhoods: Nhaminga, Mafarinha, Canhandula, Mandruze, Consito, Nhamaiabwe, Centro Emissor, Samora Machel, Macharote and Central. The population is estimated at 198,643 inhabitants, spread over an area of 2 355km², with population density of 84 inhabitants per km². The district is served by railway and road transportation networks. It has telephones, telegraphy radio and internet although working in very poor conditions which forces people travel to Beira to access services. Dondo is located at the Beira Corridor,⁸ which

⁸ It is called Beirra corridor because it facilitates commercial and business linkages in the whole country and with the regional countries such as Zimbabwe, Malawi, Zambia and South Africa.

is the central point of economic activities, with important public infrastructures including the railway and roads that link Beira with neighbouring Manica, Tete, and Zambezia provinces, thereby linking Mozambique with Zimbabwe, South Africa, Zambia and Malawi. Dondo crosses the main North-South axis of the country, and is linked to the City of Maputo through business activities. The local population is *Bangué*, an ethnic group resulted from intermarriage between Machanga, Matewe and Pondzo. In Nyanja, Dondo means tree. The name for the town is probably derived from the Dondo tree which dominates the area. Its scientific name is *African Cordyla Lour*. This is a tree with large foliage which produces wonderful shade and a fruit called *tondo*⁹. Maringue district links the northern districts of Sofala Province, namely Caia and Chemba, with the EN1 national road and Nhamapadza and Chemba districts in the northwest, with the EN 215 national road. Maringue has an area of 6.90 km², three administrative posts, five localities and 13 villages.

Administrative posts	Local level	Villages
Maringue	Maringue sede	- Nhachir - Samatene - Tucuta
	Gumbalansi	- Macoco - Massapawa - Medja
	Subue	- Maneto - Nhamacolomo
Subue	Canxixe	- Canxixe - Psico - Palame
Canxixe	Senga-senga	- Senga-senga - Wanchite

Table 4: *Maringue District Report 2006*

⁹ See (Cabral 1975:47).

Mozambique is a country with many subcultures and people in different places with specific way of behaviour and attitude that differentiate them in terms of identity. Moreover, Maringue has unique history and culture. The following is a description of Maringue and its identity as narrated by Paulo (one of my key informants):

The name, Maringue comes from the M'pata stream that crosses the mountains located in the West of the district that forms a waterfall. The name of this mountain in the local language is Mararongue, and used as a source to identify the region. In the past the water from this stream was used by the Mcombe warriors. When the Portuguese arrived, the native people in this area ran away from the Portuguese and crossed over Nghatha River and climbed Malolombangue Mountain. The Portuguese found it difficult to pronounce Mararongue and pronounced it as Maringue, and this is where the name Maringue comes from and the name was later officially recognized. The Portuguese wrote the name in a white slab at the top of the mountain that was later fixed with cement. The Nghatha River crosses over the mountain creating a water fall from the top of the Malolombangue. This waterfall created noise and that is the reason the place was called Malolongue meaning waterfall noise. On the other side of the mountain, there is another river called Nhagunde. When the Portuguese left the Zambeze river, they slept in Nhacafula, and from there they went to Sanghaze and from Sanghaze to Nhathapha until they reached Samathere to Xisaka where the community leader sent Nhathete (a hunter also known as Ntsakaima) to accompany the Portuguese to Malolombangue. The Portuguese thanked Ntsakaima and presented him with different gifts including capulanas. A

capulana, although its styles have been transformed, means a cloth that is used as clothes as presented (Picture C).

Picture C: Capulanas¹⁰



In Malolombangue, the Portuguese engraved on stones as a way of naming and registering these new names in different places during their journey. After passing Malolombangue the Portuguese travelled to Mulodzi, where they asked

¹⁰ *Capulana* is a name given to a piece of cloth that is used as clothes. According to Maria de Lurdes Torcato (2006 http://3.bp.blogspot.com/_bRcBq1-) “the origin of *capulana* is still not clear, but in Oriental Africa Swahili speaking it said that the way of dressing emerged from XIX century “when women started buying scarf (in Swahili it said *leso*) made from cotton stamped and colored, brought by portuguese merchandise from Oriente to Mombaça”..“No matter the modern modalities *capulana* is not in my perception than a descendant of ancient *bertangil* (or *bertangim*), a red or blue cloth from cotton produced in India (Surate, Cambaia, Diu and Damão), that served as coin. The prototype of *capulana* is before XIX century and I agree that start to assert in second half of XVIII century”. The history of *capulana* cannot be said without mentioning a particular technique of stamping, by intermediate of which born a type of cloth which easily identified as African. Is the batik technique from Indonesia. Other history says that *capulana* (or *kanga*, or *cloth*, or *pagne*) was born in Kenya by the middle of XIX century. The versions vary in some details but all of them indicate Portuguese as traders of stamped scarves from India, many appreciated in the region. Taking a look in the bibliography on Indic business relations it is understandable that since XVII century the Indian cloths were important trade coin and revenue source in commerce with oriental cost.

the native people to show them the way to Nhamaculo from where the Portuguese reached Gorongosa – a neighbouring district to Maringue.¹¹

When the Portuguese arrived in Maringue, they were attracted by the local environment and visited the place often. In the seventeenth century the Portuguese took over the silver mines (administrative report 2005) and introduced the '*prazo*'¹² system which did not only result in exploitation of native people, but also in taking land from them. The Portuguese took over by force the land that belonged to the native people in Quelimane, Sena and Tete. The Portuguese then called the new owner of the land by '*prazeiros*'¹³ who lived like kings. The natives were exploited through slave-like labour, paying heavy taxation and taking over local resources. This exploitation made the *prazeiros* very rich. Maringue became a '*prazo*' of Manuel de Sousa, whose main *ringa*¹⁴ or homestead was located near Gorongosa Mountain. With the death of the owner of the '*prazo*', *Prazeiro* Manuel de Sousa and with the emergence of industrialisation and commerce, the '*prazo*' system ended. People started concentrating on industries, and as a result, *prazo* system receives less attention.

The histories of Maringue and Dondo show the origins of domination of the Portuguese of the native people and their systems. The Portuguese dominated the socio-cultural, political and economic dimensions of native society. They overpowered the local people, took over their lands and overwrote their systems. They managed in the process to transform the culture of the people, but they could not take it away.

¹¹ Interview with Paulo in June of 2007, at Maringue

¹² *Prazo* is a Portuguese name meaning a farm

¹³ *Prazeiro* is the name given to the owner of the *prazo* or farm

¹⁴ *Ringa* is a homestead

Although local cultures are informal in contemporary society, they as indicated in this thesis, still influence the manner in which people interpret the meaning of their lives. As part and parcel of culture, belief systems and cultural customs practiced by their ancestors, local people still use these customs and systems for interpreting the meaning of their daily experiences. The cultural systems and practices might have changed in form, but their meaning remain the same. In responding to the challenges in daily life including poverty, health, death, and other health relate issues, people use local cultural practices to make these challenges meaningful as to make sense of experiences including emerging diseases such as HIV/AIDS.

The population of Maringue is about 61,080 inhabitants (administrative report 2006), with ten inhabitants per km². The original ethnic group of the district was the Sena-Tonga as Paulo (one of the key informants) narrated below:

...the Tongas were a small group of people that emigrated from Tambara and came to live by the sides of Nhacunde River. These people used to practice agricultural system. They were conscious of the importance of the environment. For example, it was an offence among these people to cut the whole tree. According to their culture, people were not allowed to cut the whole tree, but were allowed to cut branches. Their practice is the origin of the name of their ethnic group. They are called the Sena-Tonga that means someone who does not cut the whole tree but its half or its branches. When people visit or go to the Sena-Thonga, they use to say that they were going to the *Vatonga*.¹⁵ The original Vatonga are found between Maringue and Buzi districts, and currently served by Tambara District. Tambara

¹⁵ Vatonga is the plural of Tonga which means Tonga people/ tribe

District falls within the administration of Manica Province. People who live in the borders of Maringue district speak Sena-Tonga language. People who live in the Maringue borders with Gorongosa speak Xisena mixed with xigorongose. Other Sena-Thonga people live in Manica, at the borders of Manica with Sofala Province. These people speak a language that is a mixture of Xisena and Ximanica.

From 1895 to 1970 Maringue was divided under the administration of Chemba and Gorongosa (Administrative report, 2005). Half of the Maringue population are the descendents of the Macaranga people who presently live in the Tete Province. Local cultural dynamics played a crucial role in shaping the lives of the people and this is clear when one looks at the culture of the local people. It is clear that the culture of these people has been shaped by the culture learned from their ancestors when one considers social relations among the people. The community in Maringue is characterised by clan type, kinship and extended family relations which have tied them together. Maringue is composed of people that come from different ethnic groups, but people still relate their relations through histories of their families' ethnic groups and kinship. The chiefs among the Maringue people are still valued and powerful and people pay tributes to their chiefs and respect their rules. For example, the rites of passages for both girls and boys are initiated from and authorised by the house of the chief. Without permission from the chief, the performance or events will not take place.

People in the localities of this district know each other well. They relate to each other through histories shared and blood relations. The relations have not only tied them together, but provide a clue that as much as they value their shared history and blood

relations; they value their relations with their ancestors. The nature of many of the Maringue households is extended families. Relationships among the families are organized through patriarchy and children take the name of the father making them patrilineal. The society values patriarchy and these ties relate families together. Children, even when are adults, consult with their fathers for advice in their daily lives. Fathers have a strong influence in the lives of their children, both single and married children. These characteristics tie family together. Children see their fathers not only as parents, but also as their gods and as ancestors of their future generation, although this sense of respect is being weakened as much as beliefs in cultural practice are less valued among youth.

Mothers are also valued as parents in the society. Through their expertise, mothers advice children, particularly on the roles that women play, not only in the household, but also in the society. Women are also powerful and act as advisers, for example, during the girls' rites of passage women are expected to build character and confidence in a girl child as a way of socialising that particular child to adulthood. If a girl child misbehaves after going through the rite of passage, the society tends to blame women for failing the child. The wives (daughters-in-law) of their male children still consult with them as their mothers-in-law for advices. If these daughters-in-law take actions without consulting their mother-in-laws such actions are regarded as lack of respect. Where the daughters-in-law and the sons fail to consult with their parents, they hide the status in fear of the action that might be taken by their parents. Lack of respect can remove ties between parents and children, and children suffer the consequences, because they might be denounced and left without relations to their parents and

relatives. The reason for children valuing their relations with their parents is that children access communication with ancestors through their relations with their parent.

Both fathers and mothers play a role and make decisions for/or on behalf of their children. Children cannot get married without consulting their parents. For example, it is a tradition that *luphato*¹⁶ comes from the wealth of the family particularly that of the biological father, and be blessed by the whole family including ancestors. In the contemporary practice, and because of poverty, children collect money for *luphato*, but the roles remain the responsibility of the family. This means that the *luphato* actually comes from the parents/family. When a child wants to get married, the family prepares the whole process including the *luphato*. However, *luphato* plays different roles.

Almost all the actions taken in the families are the responsibility of the whole family, not for an individual person. All the actions are done as a way of socialising children from one generation to the next. Children learn the norms of their society through cultural practices and this is formally performed through *kuphitangano*¹⁷ education. The cultural practices become the norms of the society and make the lives of the people meaningful. It becomes an offence not only to the family, but also to the community, if an individual fail to perform certain rituals where necessary.

¹⁶ *Luphato* has the same meaning as lobola. It is a Sena word meaning the price that is paid by family of the groom to the family of the bride, as a way of creating relationship, not only between the bride and the groom but between the families, including ancestors.

¹⁷ *Kupitangano* is a process of teaching children about their culture including cultural practices. This is done through formal talks, story telling and rites of passage. The confirmation of a pass mark on passing *kupitangano* course is determined by the manner in which a person conducts himself or herself after certain behaviour has been introduced to that particular person.

The lives of the people of Maringue are guided by cultural practices and this is extended to all the dimensions of the society that are political and economic aspects. It has been presented above that the powers of the kings are still valued among these people and this forms the political character of the society. The cultural practices of the society also extend to the economic sphere. For example, when a person leaves home to find work, the family consult with the ancestors for blessings for this person. After harvesting, people are not allowed to eat the produce before paying a tribute to the ancestors. Wealth is believed to be due to the blessing from the ancestors. When people get hit by drought, they believe that the ancestors are not happy with them.

It is clear that indigenous culture in these societies guide the behaviour of the people in their daily activities including health issues, which is the concern of this thesis. There are a number of rituals that are performed by the people of Maringue such as *kupitamabzwade*, *kupitakufa*, etc that are related to health issues. Besides the families and the kinship institutions, the healers play a crucial role, not only in facilitating and sustaining cultural practice, but also interpreting the meaning of events that take place in the families, including daily experiences. The healers help people in interpreting the meaning of the fortunate and unfortunate events that occur in the society and in the family. The role of religion in most cases makes sense through the interpretation of the daily activities, experiences and events in the communities. Religion is expressed through cults to the ancestors with reverence to elders in the society. Healers are very important component of cultural beliefs and practices. They are very powerful and central in health issues including HIV/AIDS in Dondo and Maringue. There are two

categories of healers, based on the use of ancestors' spirits—the *nhamusolos*¹⁸ and the *N'anga wakuziwa mitombwe*.¹⁹ They both diagnose and heal people. They communicate with the ancestors of the clients through bones and through dreams, and medication from herbs. Apart from being important in healing, they are accessible to local people.

People have a strong belief in the use of indigenous medicine. In Maringue, a number of cultural practices are central in health, and this has impact not only on general health issues, but also on HIV/AIDS prevention interventions. In the individual's first experience with a disease, including *phiringaniso*/AIDS, healers are the first health service providers to be consulted, before the biomedical doctors, hospitals and clinics.

The two districts have different political backgrounds. Dondo is pro-Frelimo, Maringue is pro-Renamo, and during the time of this study, the Renamo headquarters was in Maringue. The fact that Maringue was strongly pro-Renamo justifies Maringue district's poor status when compared with other neighbouring districts. Maringue is one of the districts that does not have electricity, running water; telecommunications including land lines and mobile telephone networks was introduced only in 2008. There is only one secondary school in Maringue. People from all over the country come to Maringue

¹⁸ *Nhamisolo* is a healer who acquired the power of healing through a given power directly from the ancestors and *Nhamusolos* is plural. This healer uses both bones and direct spirits in terms of spirit possession to interpret and to communicate with the ancestors, and herbs as medication.

¹⁹ *N'anga wakuziwa mitombwe* is a healer who inherited healing powers from a dead member of the family and through learning. This healer uses bones to interpret and to communicate with ancestors and medication from herbals.

for business. Like in Dondo there are many *barracas* in Maringue, and in general, businesses develop and flourish despite lack of electricity, clean water and other basic services. The economic status of these two districts is poor and has a direct impact on the people, and can justify the persistence in the use of indigenous medication.

It is mentioned above that people use cultural practice and indigenous health service because they value their culture and their ancestors equally. This culture has been carefully transferred from one generation to the next through socialisation. For this reason, they understand and are able to interpret their health practices including medications. It is true that people continue cultural practices or indigenous medicine partly due to limited access to biomedicine, but this thesis adds a different explanation. Cultural practices, especially the use of indigenous health medication is said to be a means of survival due to the limited access of biomedical services, but also as a source of justice and revenge to those who dare any kind of malice to achieve any objective; as Niehaus (2001:129) says it is “still a marker of unique and primordial identity”. Thus people still tell stories of their experiences in the use of supernatural powers to harm or to revenge. One of these stories is the story that Pedro Herculano, a 45-year-old man, a typist administrator and a healer, narrated to me during my fieldwork. This is the story about his personal experience. During the course of my conversations with members of the community at one of the local bars, Pedro told the following story:

One morning, when I was about to wake up from my bed, I was nearly struck by a snake. As usual, my wife woke up before me. I turned myself (change the position) to face the bed position that my wife usually use and stretched my hand to greet her, but only to find that she was already off the bed. I found myself nearly

sleeping on a snake. I felt something cold and freezing and I immediately jumped off my bed to check what it was. I jumped off the bed, but it was too late because this snake jumped together with me and coiled itself around my leg. I struggled with the snake, trying to free myself from it, but I could not win before the snake bit my leg. I started to cry and scream. Due to the use of my power, my supernatural powers as a healer, I freed myself from this snake and held it with my hands and asked my wife to bring me a large bowl that I could use to capture this snake. I placed the snake inside the bowl and closed it and left the bowl in the sun. It was a very hot day and I left the snake there for the whole day. In order to keep myself busy, I asked my wife for some money and I left for *barraca*²⁰ to drink some *cerveja*.²¹ I took a lot and when I came back home, it was already late and I started shouting as a way of telling the owner of the snake to identify himself/herself or else. The owner of the snake did not show up. But three days later, I was told that a man, who I assumed and believed was the owner of the snake, had fallen sick. He approached me and pleaded with me to free his snake because if his snake remain captive, he will continue getting sick, and if that snake dies he will die too. In his pleading he explained to me that he was deceived by another healer. This healer had promised him that the snake will kill me and he will be taking over my position at work. I could not care about him because he wanted

²⁰ *Barraca* is the place where people drink beer and have food to eat; a *barraca* is an ordinary shebeen. It means a small hut or shed where alcohol and food are sold. Nowadays, however, most of them are adjusted with rooms for rent to those who want to have sex. This is the reason why people say that the emergence of *barracas* are promoting prostitution in the community, and therefore, also responsible for the increase of HIV and AIDS.

²¹ *Cerveja* is the Portuguese word for beer.

to kill me. I asked him to leave my house and said to him that the snake will remain a captive. The snake died and he followed his snake.

Pedro' story is an example of cultural practices which are embedded on beliefs and the need of their preservation. The need of preservation is due to the popular concepts of health and disease that cultural practices (rituals), magical methods and the evocation of witchcraft constitute an integral part of traditional healing. Although dangers of misuse or harmfulness of some of these techniques are evident (Bannerman et al. 1983:311) the use of indigenous health medication is said to be a means of survival due to the limited access of biomedical services, but also as a source of justice and revenge to those who dare any kind of malice to achieve any objective. Like Pedro story, experiences in the use of supernatural powers to harm or to revenge can be viewed as witchcraft and sorcery activities which according to Staugard (1985) are the two principles or forms in which the black magic occurs. However, the two principles have different meanings and interpretations, while witchcraft is described as an innate quality and an involuntary personal trait it is said to be hereditary condition and provides a theory of failure misfortune and death.

Pedro pointed at one of his friends to confirm or testify the truth of his story. One of the men sitting with him said: "Yes, everybody in this village knows about this story".

These kinds of experiences are some of the reasons for the persistence of cultural practices. When a person experiences misfortune caused by supernatural power, people consult healers, because it is only the healers who have powers to interpret the situation and to heal. It is clear that the practices among these people are aided from the

postulated structures, and approves these practices as organization with functioning of the supernatural (Smith 1986:54) and this creates a supernatural social world.

Besides being the acts of revenge, this kind of a story indicates the rationalization of the customs and behaviour in the community. It elaborates a discourse of social relations that justifies the nature of behaviours and attitudes among people who use the power of healing to eliminate other people. However, the story demonstrates the coexistence of elimination and healing, which means that the same power can be used to eliminate and also used as a healing power.

The dynamism of the biomedical approach is that it can control and manipulate what seems to be difficult through scientific methods of healing. But the African healing approach reveal what make sense to people's daily experiences and according to the way these people interpret their social world, including health issues. There are different reasons for the persistence of indigenous practices which are still common in Maringue and Dondo. But the main reason for sticking in these practices is due to the fact that people still value their ancestors, and that they see something tangible about their practices. Yes, cultural practices have impact on health issues, but the results depend on the approach and the methods employed.

CHAPTER V: VOICES OF YOUNG PEOPLE, KULANGIWA IN THE CONTEXT HIV/AIDS

This chapter presents reasons why youth are heavily affected by HIV/AIDS and this involves issues around behaviour, sex, sexuality, and accessing information about HIV/AIDS including its prevention interventions from different contexts of society. The discussion around the issue of accessing information relates to what parents and other groups say about the meaning and the need of initiation rites like *kulangiwa*,²² and how the rites of passage have been transformed, first by colonial intervention, the government and the civil war. The chapter further discusses different points of view and concerns of young people (from the secondary schools whose age range from 11 to 30 years old) in relation to the knowledge and behaviour as expressed by the school youth. HIV/AIDS is reportedly concentrated much among youth. This chapter discusses the perceptions of young people and their concerns on matters of sex and sexuality in the context of HIV/AIDS.

According to parents, young people are at risk of HIV/AIDS because of the manner in which they conduct themselves. Some parents argue that young people do not respect the culture and values of their ancestors anymore, because they were not socialised or raised according to the culture of their ancestors since the society is being transformed daily, as some parents no longer value the local culture. They, therefore, understand

²² *Kulangiwa* is a rite of passage for young people

little about the culture of their cultures and ancestors. Moreover, because nothing or no culture has been made available for them to construct the meaning of their lives, they as a result, make decisions that jeopardise their future, as one community leaders asserted in the quote below:

“our children do not take our advice; they rather listen to their friends. Peer pressure is a problem. How can a child advise another child, they are all children and understand nothing about life. The situation is worse because there are competing cultures that confuse them. Children mix all these cultural practices. The problem is that parents are not doing better for their children. They too have rejected old cultural practices for socialising children. *Kulangiwa* is no longer practiced regularly among our people. Parents have adopted other ways of raising their children and nobody can pinpoint which ways they are since they are too many and not structured. But even if we can pinpoint them; it is obvious these ways are not effective. If they were effective, our children would not have been in the situation they are facing today”.

Kulangiwa is a ritual for teaching young people about life. The word *kulangiwa* is a Sena word formulated as follows: *Ku* is a prefix meaning taking an action or to perform and *langiwa* means counselling. During puberty, young people go through the *kulangiwa* ritual as a way of introducing them into adulthood. The ritual is said to be no longer a regular practice in Dondo and Maringue. Initiation rites are crucial in providing young people with education that benefits them in their social life. *Kulangiwa* educate and help to build respectful behaviour among young people. These days young people have sexual debut at an early age, because of lack of *kulangiwa* education. Lack of respect

and changes in norms influence sexual debut and risk of infection with HIV among young people.

The chapter discusses the background to knowledge that influences the behaviour of young people. The behaviour of the children is influenced by the environment within which they are socialised. The discussion elaborates on the behaviour with impact on HIV/AIDS among youth. During fieldwork young people indicated that they acquire different knowledge about their society including HIV/AIDS from different spheres of the society with each sphere influenced by its own culture and cultural practices some of which are in conflict. Dondo and Maringue communities are multi-cultural and comprise both western and local traditional culture, each with its own cultural practice. All these cultural practices have influence on individuals with different impact.

Besides being exposed to different cultures and cultural practices, young people are socialised differently depending on the approach each sphere takes. For example, some parents choose western culture and some choose local traditional culture, while others accommodate both. Although parents are central in influencing how children view the world, young people also learn and obtain knowledge from different spheres, including global, national (Mozambique), societal (Dondo/ Maringue) and local arena (local areas including individual households). Figure 9 presents some of the spheres where children get information about sex and sexuality, including information about HIV/AIDS and prevention intervention strategies.

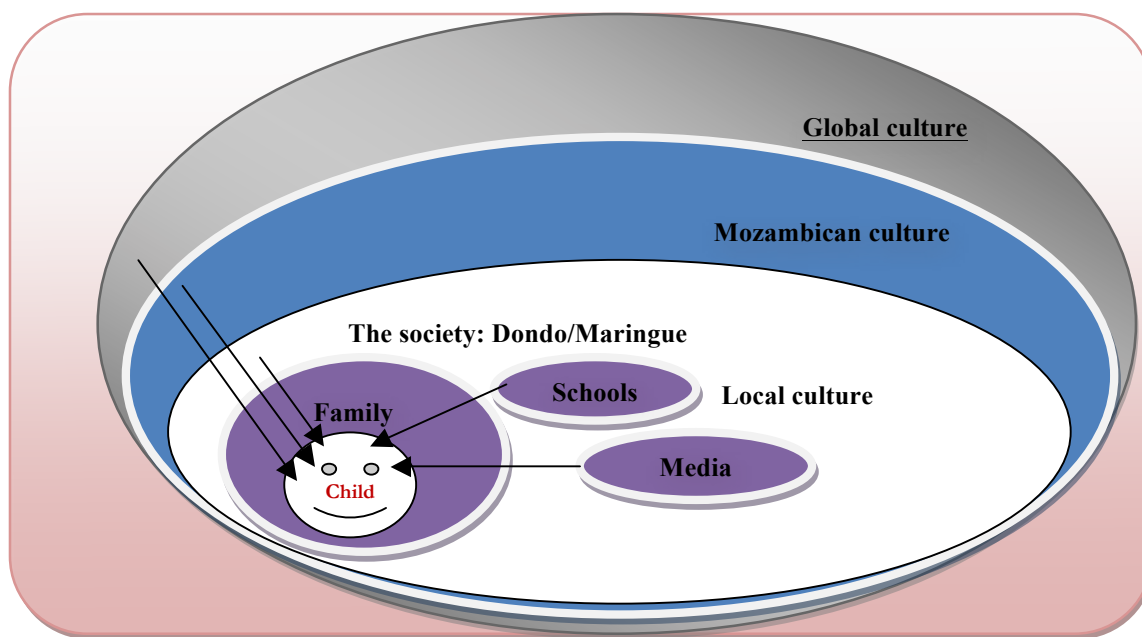


Figure 9: *The sources of information on HIV/AIDS*

Although some spheres are influenced by similar cultures and cultural practices the approach and the manner in which the information is provided to the children differ. Children get information from a complex society that is multicultural with different cultural practices, and just as the society is complex so is the knowledge about culture. It is mentioned above that each sphere of the society has its own culture; the problem is that all the spheres represented in Figure 9 have a direct influence on a child. These children learn same things differently from schools, media, parents, peer, public organizations, etc. The same applies to the knowledge on HIV/AIDS. HIV/AIDS is experienced and interpreted differently in different spheres of the society. The interpretation or perception is determined by the kind of culture and cultural practices dominating a particular area. This makes knowledge not only a complex issue, but also inconsistent among young people and bring confusion. The problem of knowledge complexity and inconsistency cascades to HIV/AIDS including prevention intervention strategies.

This situation is not as simple as one would imagine because young people acquire knowledge from different institutions and actors ranging from school, public spheres, HIV/AIDS prevention campaigns, and community including parents. This may mean learning from a chaotic environment. Acquiring knowledge from different spheres that are influenced by different cultures may mean that misunderstanding is inevitable. The situation is problematic because children receive knowledge that is inconsistent and use this knowledge in decision-making in daily life.

Discussions on issues concerning youth include questions that are not viewed as central among HIV/AIDS activists, although these unrecognised issues are central to HIV/AIDS prevention. During group discussions between students, community leaders, religious leaders, health professionals and NGOs, there was a view that the youth is socialised in complex cultural contexts. The view was moreover expressed that local cultural practices should be reintroduced for socialising their children. Rituals for both girls and boys were considered crucial because rites of passage teach respect and acceptable behaviour that do not only benefit youth in terms of respecting other people, but also self respect in the way they conduct themselves. As Kotany and Krings-Ney (2009: 1) say “the initiation rites turned into a process of empowerment for women in their own communities.” With knowledge acquired from initiation rituals the young people would be able to avoid exposing themselves to risky behaviours, including behaviours that expose them to infection with HIV. According to the community leaders morality in sexual behaviour is crucial for HIV prevention, and this is lacking among youth.

***Kulangiwa* Initiation Ritual for Youth**

Kulangiwa or *maseseto* are terms from Sena meaning being in process of counselling. It is the process of introducing a teenager into adulthood. For example, boys learn how to participate in community decision-making. They also learn how to respect persons older than them. Besides teaching the youth about respect, the ritual is also a process of learning intimacy. Young people are taught how to conduct themselves in sexual matters. During the initiation, adults talk about sexual organs and anatomy openly to the apprentices. Furthermore, they undress and become naked in the presence of apprentices, particularly when they perform the ritual dances. These take place only during initiation ceremonies. Kring-Ney et al. (2009) argues that outside of the ritual ceremonies, it is considered obscene and shameful to name female reproductive organ. But during the initiation ceremonies naming the female reproductive organ is the norm. This symbolically means that the apprentices are welcomed to the world of adults.

Although the initiation rites are not regularly performed today as was in the past before the independence of the country (that took place in 1975). Initiation was a common way of initiating a child from one stage to the next. From 1997 time the government decided to ban the ritual with the objective to discourage the premature marriage of girls, they are still practiced in Dondo and Maringue.

Initiation prepares a girl or a boy for marriage including how she/he should conduct herself/himself in marriage and in society as a whole. It was argued during focus group discussions in this study that *kulangiwa* should be reintroduced. Such reintroduction was considered necessary for educating and preparing young people for adulthood.

Kulangiwa is a rite of passage for teaching young people about their future roles and responsibilities as adults and members of the community.

In addition, the initiation ritual educates young people on matters of sex and sexuality including the meaning about changes in their bodies. Boys are taught how they should take care of their families, including their wives when they get married. A man must know when he should have or avoid sexual intercourse with his wife. He should, for example, know it is against the custom to have sexual intercourse with a woman during menstruation, as it is believed to be impure. It is also against the norm to have sexual intercourse with a woman that is eight months pregnant to safeguard the unborn child.

The rite of passage provides education for girls regarding how to take care of themselves especially during menstruation. Girls learn about menstruation which is considered to be a very especial period for a woman. Menstruation means pollution, dirt and hotness, and is thus considered dangerous to people's health. At the same time it is beneficial because it is a cleansing system from pollution and dirt, including infections. Thus, in order for a woman to keep her body in good health, sexual intercourse during this period must be avoided. Girls too learn how to preserve their virginity. Virginity is considered important, because it is used to measure the value of a woman who is about to get married. It is a symbol of pride for the parents, godmother, relatives and the community. If a girl has preserved her virginity to marriage, it is a sign she has respected the instructions she learned from the initiation school.

Kulangiwa ritual for girls, according to one of the informants, takes place in two different stages. The first is in the pre-menstrual stage when a girl is between 8 and 11

years old. Her family nominates a female person to be the girl's educator, who is referred to as godmother (*phunga*²³) by the girl. It is a norm that the chosen godmother is a woman aged 45–50 who has passed through the correct stages, referring to initiation rituals, married with children, especially having experience with raising female children. Another reason for choosing a woman of this age is that a woman at this age is viewed as having enough experience with life and with high possibility of being at the menopause stage. Menopause is crucial because such a woman is unlikely to put people at risk of impurity. As argued above, menstruation is partly impure or hot, and can affect the health of people in a particular family and in the community. During the first phase of initiation the godmother teaches the girl to elongate her labia minora. *Nfuta*²⁴ is used to moisten the labia minora in order to minimize the pain during elongation. Elongating the labia minora is considered still very crucial in Dondo and Maringue, because it is believed to enhance sexual pleasure and also as a mechanism to sustain marriage for a woman. This is still the case among these people, although some devalue this practice. Thus, if for some reason a girl marries without elongating her labia minora, she would be returned to her parents for preparation. Parents then consult her godmother or nominate another person to assist her with elongation and then take her back to her husband.

A woman can be a *phunga* for more than seven girls at the same time. This group of girls would consult with their godmother on daily basis. They would go to the godmother's place for training and go back to their homes after each session. In this way, parents were able to monitor the whereabouts of their children. Furthermore,

²³ *Phunga* means a godmother.

²⁴ *Nfuta* is an oil made from herbs that moisturizes the body of a person.

these girls would grow up together as friends, and influence each other in life, basing their behaviour on the instructions learned from their godmother.

The second phase of *kulangiwa* takes place when a girl has her first menstruation. The girl would know what to do as she had been given instructions by her godmother. The girl takes the first cloth used as a menstruation sanitary towel to the godmother. Since menstruation is a personal experience, the girl would not wait for other girls in her group to enter the second phase of *kulangiwa*. *Kulangiwa* process was a secret between the godmother, the girl and her parents. To avoid making people suspicious why a particular girl is spending time in another woman's house, the girl should have developed a friendship with the godmother's daughters or any persons around the *phunga* during the girls' first phase, so that people would thus assume she was only visiting her friends.

The second phase in the initiation process takes place when the girl is about 12 to 16 years old. When she menstruates, the godmother would burn her first cloth used in the form of a pad or sanitary towel, mix a bit of the ash with soft porridge and give the mixture to the girl to eat. This procedure was believed to have power to regulate the flow of menstruation and reduce menstrual pains in the girl's menstruation periods. This was also believed to prevent premarital pregnancy. If the girl followed instructions from her godmother, it is believed that the menstruation period will last only three days. A girl would also learn domestic and agricultural activities from her godmother since as an adult woman her duty is to support her family in reproductive and productive labour.

Just as the elongation of labia minora is a concern between the *phunga* and the girls, sexual skills are also a concern between the *saphunga*²⁵ and the boy. One of the important teachings for both girls and boys is about the bridal night. Since virginity is important for both girls and boys, the boys are taught *chiswakongo*,²⁶ a *Sena* word: *chiswa* means to break and *kongo* means a woman sexual organ or a vagina.

Kuchiswakongo means break a virgin, literally means the process of breaking virginity. Thus, the process of *chiswakongo* teaches boys about their responsibility on what they must do when they get married in terms of sexual intercourse and the purpose was thus to qualify a boy to marriage and to educate him about his responsibility to his wife and his family. This is one of the reasons the ordeals at initiation are often about sexual organs and activities. The practice is labelled as a privilege for adulthood, marked as important through the pain that is associated with ordeals and sacralised by invisible powers. Furthermore, the reason why the bride and the groom have to perform sexual intercourse on the bridal night under the supervision of the *phunga* and the grandmother of the girl was to check both the virginity status of the boy and the girl, and if the boy would be able to produce children. The boy's reproductive status is determined by the thickness of the sperm that he would produce during the bridal night sexual intercourse. If the sperm produced is too watery, the parents of the girl would give a chance to the family of the boy for two years to prove himself that he is fertile or can produce children.

Parents, healers, religious groups including Catholic Christians, community leaders all viewed initiation rites as a practice that can control or regulate the behaviour of young

²⁵ *Saphunga* means a godfather.

²⁶ *Chiswakongo* is a root that is given to a boy by the godfather to massage his penis.

people. Initiation ritual can obviously be used to reinforce certain behaviour around HIV/AIDS prevention among girls and boys. They believe that public formal educations, dominated by western culture, are not doing enough in building morals in young people. For example, they see the failure of schools, public health institutions and NGOs in building morals around sex and sexuality as central in the spread of HIV/AIDS, with the result that HIV has spread fast in Mozambique.

Local people in this study expressed concern over the disappearing significance of their culture. *Kulangiwa* ritual, according to them, should be encouraged for teaching young people how to conduct themselves as well as learn how to become responsible adults, obey rules, and take care of their families.

As discussed above parents argued that young people expose themselves through risky sexual behaviours for which they are vulnerable to infection with HIV, mainly because they do not receive proper education about life. From this study, rites of passage in the northern and central Mozambique suggested the value of integrating HIV/AIDS prevention within the counselling in the initiation rites (Kring-Ney et al. 2009). According to Kring-Ney the fact that the youth learn to be responsible for others also help them to respect themselves and this would help them avoid getting HIV infection. Thus, in focus group discussions and interviews with key informants in this study, mainly community leaders, the need for bringing back the initiation ritual was emphasised. One informant argued:

Kulangiwa can assist in controlling bad behaviour among our children. The education that the *phunga* give to the girl or that the *saphunga* give to the boy

carries in it the future of our children. The *phunga* and the *saphunga* teach our children about the consequences of engaging in sexual intercourse. They counsel them and from there a child would know that it is not allowed that she/he be engaged in sexual intercourse without the permission from the parents. It is the parents who should permit children to have sex and this should be declared by the parents that their children are now adult and can get married. It was an offence and an embarrassment, not only to the parent, but also to this child and the entire society, if he/she could get involve in sexual intercourse before marriage. Children knew that to break this rule was equal to dishonouring the teaching that they receive from *kulangiwa* education, and disrespect to the parents. If a child, for example a boy happens break rules in sexual intercourse without permission the family would call the meeting with the elders of the community to charge a boy who had sexual intercourse with a particular girl to pay a tax for dishonour. A girl was allowed to marry from age 18, but during the marriage ceremony the girl was subjected to an inspection to verify her virginity status. The same applied to boys, procedures were taken to verify if the boy would be practicing sexual intercourse for the first time during the marriage ceremony” (Community leader, June 2007).

The community leader elaborated on how the rites of passage benefit the youth, the parents and the communities. Parents were able to control the behaviour of their children through the *kulangiwa* rite of passage. Children would, in turn, know the consequences of disobeying the rules they had learned. This cultural practice benefitted both the children and the whole society. The current sexual behaviour encourages, risky sexual practices, which facilitate the spread of diseases. If *kulangiwa* is

reintroduced, it would bring a sound system to regulate the manner in which children/youth should conduct themselves.

Transformation of *Kulangiwa* Ritual and its Impact on Youth

The abolition of the initiation rituals after Independence in 1975 was part of the government's postcolonial transformation process. During the transformation process, people were forced to denounce their traditional practices, without assessing the importance of these practices and the future results of eroding these practices. I argue that it is not advisable that people throw away their cultural practices when they get introduced to new styles. What is important is to assess the current situation and weigh the competency of the new cultural practice from the context of their society.

The community blames the war for being responsible for forcing girls into sexual intercourse at an early age and early marriage, as one elder in Maringue argued:

“Soldiers raped our children and exposed them to sex at early age. The damage that they caused still exists today. For 16 years experience in war, a 16 years period of soldiers destroying our customs. Girls started to be engage in sex at early age. It is difficult to reverse the situation. The damage that the soldiers caused to our children was accompanied by the current environment, with the freedom that children claim to have. We are not able to discipline our children. You will find a child telling her parent that she has rights; how can a child have rights to do what ever she/he wants in your house?”

Transformation from one culture to the next resulted in people abandoning their own customs. War turmoil furthermore weakened the environment leading to a chaotic situation. This transformation in culture and abandonment of cultural practices eradicated the moral values regulating marriage. Parents find themselves marrying “their own daughters,” to men who, according to their age, can be their fathers. According to the cultural custom this is an offence.

Community leaders perceive the social disorder as created by the absence or suspensions of the usual order of social relations. Santos (a community leader in Maringue) gave an example of a social disorder that resulted from war in Mozambique, where soldiers used to rape girls and steal their virginity thus placing them in a vulnerable situation. As a result, girls started to contract STIs. This chaotic situation exacerbated the increase in the number of girls who were devalued in the society since a raped girl no longer had value in the society. Parents would do anything to ensure that their raped children regain value through marriage. Parents should not care about assessing the status of their future sons-in-law; the only thing they cared about was that their daughter gets married.

The wars forced girls into unfamiliar roles. Young girls could employ desperate means for accessing food. As a result, young girls assumed adulthood roles and responsibilities at an early age, especially when the situation ended with pregnancy after rape and sexual violence. In spite of all these transformation, war and turmoil diluting cultural practices, the current risky behaviours among young people are said to be the parents’ failure to initiate their children, the government’s failure to recognise

the importance of *kulangiwa*, and as the children's own responsibility because of neglecting the teaching, as one of the healers expressed during an interview:

This kind of marriage (getting married at early age) was initiated by young children who decided to go against our norms. Even if children passed by the initiation school, they decide to disobey the norms that they know that they are true facts. We understand and accept that the 'civilized' would not want to perform any 'uncivilized' rituals, but this attitude had led them to immoral practices. Early marriages are not part of our customs; they were never part of our tradition. Our ancestors knew the consequences of early marriage, and they had therefore prepared us a tool that would help us to avoid these kinds of practices. *Kulangiwa* is one of the tools that were made available to us to guide our behaviour. The practice of getting married at an early age and sexual intercourse before marriage started with the so called popular culture. People started to practice lifestyles that they learned from the cities and bring them back to our people. It was disappointing because they just take things and swallow without digesting. They did not understand what they were bringing back home. They brought shame to the lands of their ancestors. The dilution of our cultural practices was followed by war that started in 1983. Soldiers destroyed the quality of our children; we ended up 'not having girls'. According to our culture a girl maintain her status of being a girl through the manner in which she conducts herself. We understand that these girls did not expose themselves to sexual intercourse, but the issue is that if a girl gets touched she destroys her quality of being a girl, and that remains a fact. We blame wars for exacerbating premature and unlawful marriages. Soldiers forced girls and older women to become their

wives. They caused chaos in the environment of our cultural practices. From that time people started doing things according to their thinking without guidance from our traditional laws.

According to this healer or the narrator in the above story, the increase in HIV/AIDS among youth resulted from the abandonment of *kulangiwa*. *Kulangiwa* remains an important tool for parents in socialising and teaching their children on how they should behave from the teenage stage to adult stage. *Kulangiwa* is a developmental process, for youth, because if the child fails to behave according to the teachings received from the family through the *phunga* or *saphunga*, it means that the particular child has failed the *kulangiwa* class.

Counselling entails separation of children from their parents and the household they have been brought up, and symbolically from their childhood (Woodburn 1977). If a child fails to behave according to parental teachings, it is the failure of this particular child not the parents. It is argued in this chapter that the life that the child lives before initiation ritual is the responsibility of the parent, and that the life the child lives after the rituals, is the responsibility of the child. A failure to behave according to what has been taught during the initiation becomes his/her responsibility. A person that has passed through the rites of passage is considered an adult and the community does not expect behavioural deviation of any kind, such as disrespectful behaviour including premarital sexual relations.

The 1975 national unity government's prohibition of *kulangiwa* practice was the government's failure to understand that the initiation rite consist of a set of symbols

that operate and socially communicate and provide meaning to reality (Dornelles 2002). Rites fundamentally serve the basic social function of creating and maintaining solidarity among communities (Bell 1997). The prohibition of *kulangiwa* was not substituted by any school that could take over in providing the lesson taught in *kulangiwa* and this means that nothing was provided as a tool of socialising children according to the norms of any recognised culture. As a result of this social cohesion was no longer enforced. From that time, the future generations could not receive any education with reference to their communities. The social environment therefore became chaotic in terms of socio-cultural structure. With the emergence of HIV/AIDS there was nothing available to guide children on what to practice and what to avoid. The children therefore became victims of the chaotic environment in terms of cultural practices.

It is not deniable to declare that the 1975 government's decision to ban the rites of passage was a failure to realise that rites of passage are an overall initiation means of accessing good behaviour. In other words, rites of passage prepare children for a better future.

Mozambique as a country is part of a global village which is characterised by modern environment (Van Gennep cited in Bell 1997). In our modern society there is minimum practice of formal social rituals. This is correlated to the lack of tools in dealing with the modern social ills like HIV/AIDS. People are in the state of confusion because they do not use these social rites of passage to guide their behaviour.

Revival of *Kulangiwa* Ritual

Currently there are signs that show the reawakening *kulangiwa*, although the revival has taken a different form. In Beira, for example, as broadcasted by the Mozambican Radio station (MR) on Saturday evenings, broadcasts some teachings learned in *kulangiwa*. The radio broadcasts an education programme called “*ndzindzi wa maphungo*” which means education time [literal translation]. “*Ndzindzi wa maphungo*” contributes in educating young people about behaviour. It is a kind of moral regeneration on how people should conduct themselves. This is an isolated approach, as it was not initiated by the government or as being part of the national education strategy towards contributing to the behaviour of young people in relation to issues around HIV/AIDS and its prevention intervention strategies.

The interest of this chapter was to discuss the rites of passage in order to demonstrate the role of rites of passage to the lives of the people, including lifestyles or the manner in which people conduct themselves in relations to sex and sexuality. The rites of passage in Maringue and Dondo were crucial in demonstrating how people interpret their behaviour through these rites of passage, and how these rites of passage guide the construction of the social environment, including the meaning of certain behaviours.

The Meaning of the HIV/AIDS Prevention Interventions to the School Youth

This section is based on questions generated from the school youth. Use of self-generated data in form of questions has been described in the methodology chapter. The self-generated data technique was used to explore the perceptions of the young

people on the meanings of HIV and AIDS prevention interventions. In order to achieve this objective, data was collected from 352 students who were asked to write questions of concern about sex and sexuality in the context of HIV/AIDS. Students expressed their concerns in the form of questions. Later, group discussions were conducted with students and teachers together with the NGOs involved in health care, healthcare officials and PLWHA as a way of reflecting the questions asked by the students. As described in the methodology chapter, all the students were from Dondo and Maringue secondary schools.

Lack of consistent information on HIV/AIDS prevention programs among young people is reflected in the many questions and concerns expressed by the students. A number of questions indicated that the young people were sexually active although not necessarily protecting themselves against HIV/AIDS. One of the burning questions that students raised was a question on how people can fight against the spread of HIV/AIDS in schools which means the young people are equally concerned about the spread of HIV/AIDS. During analysing the questions were categorised according to the following issues:

- Question on the origin or history of HIV/AIDS
- Questions on the impact of HIV/AIDS
- Question in relation to prevention interventions
- Attitude that influences certain behaviour against prevention
- A concern about certain kind of behaviour
- Questions in relations to cure for HIV/AIDS
- Education/socialisation/initiation and
- Other social related issues.

The youth were not ignorant about the impact of HIV/AIDS in society, and their decisions and behaviour were determined by the knowledge that they have. Their concerns revolved around the history of HIV/AIDS as a disease. Their interpretation of HIV/AIDS was influenced by both biomedical and traditional interpretation, but they did not have the full understanding of both approaches. Furthermore, it was clear that these children did not receive appropriate and consistent information about the issue around sex, sexuality and HIV/AIDS including HIV/AIDS prevention interventions strategies.

❖ **Questions on the origin or history of HIV/AIDS**

1. Did our ancestors suffer from HIV/AIDS? (14-year-old boy)
2. What are the reasons behind us suffering from AIDS? (16-year-old boy)
3. Who brought AIDS into our country? (16-year-old boy)
4. Is AIDS there only in Mozambique? (14-year-old girl)

❖ **Questions on the transmission of the disease**

1. How does a person get a sexually transmitted infection? (13-year-old girl)
2. How is HIV/AIDS transmitted? (15-year-old girl)
3. In the first sexual intercourse could you get HIV? (15-year-old girl)
4. How can a pregnant woman transmit AIDS to her baby? (14-year-old boy)
5. Can someone transmit HIV/AIDS through kissing? (14-year-old boy)
6. Is AIDS only transmitted through sex? (17-year-old boy)
7. Who is most exposed to HIV and AIDS: a person who has sexual intercourse or a person who masturbates? (22-year-old girl)

8. Do those who fail to perform rituals related to death get AIDS? (21-year-old boy)
9. How does a person transmit AIDS if it is said that people can eat together with those infected? (15-year-old boy)
10. Are there chances for a man who sleeps in the same bed with his spouse to become infected? (17-year-old boy)
11. Our parents refer to AIDS as a mystery disease. How does it affect everyone, including those who did not offend traditional practices? (18-year-old girl)
12. Do AIDS come from humans or animals? (15-year-old boy)
13. Is it only girls who can transmit the infection to boys? (13-year-old girl)

❖ **Questions in relation to prevention interventions**

Resources

1. How can we prevent AIDS? (15-year-old girl)
2. Where can we receive treatment—from healers, hospital or at home? (16-year-old boy)
3. Can we prevent AIDS with African medicine (22-year-old boy)
4. How is antiretroviral treatment helpful? (18-year-old boy)
5. At what stage of a HIV/AIDS-related health condition should one take antiretroviral treatment? (18-year-old boy)
6. Is abstinence from sex the only safe way to prevent getting AIDS? Why? (14-year-old boy)
7. Will you not have AIDS if you have only one sexual partner? (20-year-old boy)

❖ **Questions on the availability and impact of the use condoms**

1. Why does the government make condoms available? (20-year-old boy)

2. Apart from condoms, doesn't the government have other ways of preventing the AIDS infection? (18-year-old girl)
3. Is condom use, the best way to prevent infection? (18-year-old boy)
4. Apart from condoms isn't there another way to prevent unwanted pregnancies? (18-year-old girl)
5. Is it safe for an HIV-positive couple to have sex without a condom? (14-year-old girl)
6. My girlfriend tried convince me to have sex without condom because in her view condom is a business and they are infected with the virus to diminish Mozambicans (18-year-old boy)
7. In the voluntary counselling test it is said that we must use condom but other people say that condoms are infected. Which condoms are infected? (22-year-old boy)
8. Is it true that if you use condoms you cannot get AIDS and STD? (17-year-old girl)
9. Are condoms solely used to protect from AIDS or are used to further other interests? (19-year-old boy)
10. Is it true that condoms are infected by AIDS or viruses? (18-year-old boy)
11. Does the condom only protect from getting AIDS? (15-year-old boy)
12. I trust my girlfriend. Why must I use a condom? (19 year-old boy)
13. Some churches do not accept the use of condoms. Does it mean their members do not get HIV? (20-year-old boy)
14. How can we be sure that the condoms from the hospital or the market are not infected? (18-year-old boy)

❖ **Concerns on contradictory information**

1. Some people say those condoms are infected. Is that true? (18-year-old boy)

2. Why is it said that after a man uses a condom and it splits before sex he has to wait until the following day for sex or he has to get a new condom? (22-year-old girl)
3. The condoms that we use are they infected or not? (20-year-old boy)
4. I would like to know whether the liquid inside the condom is artificial or not (20-year-old boy)
5. Is it real that condoms do not have a virus or are not infected with AIDS? (18-year-old boy)
6. Why is it that nowadays it is said that condoms are not 100 percent safe? Is that true? (18-year-old boy)
7. Is it true that a truck driver contaminated condoms with HIV? If yes, how can we know if a condom is contaminated or not? (18-year-old boy)

❖ **Signs of having little knowledge about prevention (concerns to HIV/AIDS campaign)**

1. Can you get AIDS if you have sex wearing ten condoms? (20-year-old boy)
2. If I have sex wearing 4 condoms could I have the same pleasure as if I had 1 condom? (21-year-old boy)
3. I love my girlfriend a lot. If she is tested and the result is positive what can I do? (22-year-old boy)
4. Why is difficult to be faithful? (14-year-old girl)

❖ **A concern about refusing to use condom and other related risky behaviour around sex: sexuality and HIV/AIDS prevention interventions**

1. What kind of method that can be used with a partner who refuses to use condoms? (18-year-old boy)
2. Why do people practice sex without condoms? (15-year-old girl)

3. My girlfriend does not want to use condom. What can I do because I do not want to lose her? (16-year-old boy)

❖ **Questions in relations to cure for AIDS**

1. What can we do to eliminate HIV/AIDS? (14-year-old boy)
2. Is it true that AIDS has no cure? (14-year-old boy)

❖ **Knowledge Transmission**

1. Why do men die of AIDS earlier than women? (19-year-old girl)
2. How does a person transmit AIDS if it is said that people can eat together? (15-year-old boy)
3. Is there a chance that men who sleep in the same bed as their spouse become infected? (17-year-old boy)
4. Can a woman become pregnant only by having a penis inserted in her vagina? (15-year-old girl)
5. Is it only girls who can transmit infections? (13-year-old boy)
6. From what age can a girl/boy have sex? (13-year-old boy)
7. To be in love is part of culture or not? (16-year-old boy)
8. I do not understand what oral sex means? (16-year-old boy)
9. Why do human beings practice sex? (15-year-old boy)
10. Why do men like to practice sex? (14-year-old boy)
11. Why do women fear having sexual intercourse when they are menstruating? (17-year-old boy)
12. When boys wake up in the morning sometimes they find out that the mat is wet. What can they do to stop that from happening? (18-year-old boy)
13. How does a person get pregnant? (13-year-old boy)

14. I have many problems with my body: my urine has a yellow colour; I feel weak and I feel pain; but I never had sex with any woman. Why has this happened to me?
(16-year-old boy)

❖ **Lack of education (*kulangiwa* education) on changes in body**

1. Where does menstruation come from? (13-year-old boy)
2. What is menstruation? (13-year-old girl)
3. How is menstruation transmitted from one woman to the next? (13-year-old girl)
4. Is menstruation a disease? (15-year-old boy)
5. When men start having sex at a late age, do they suffer from genital pain the first time he has sex with a woman? (20-year-old boy)
6. Why am I wet when I wake up in the morning? (14-year-old boy)
7. What is a wet dream? (15-year-old girl)
8. At what stage of sexual intercourse ejaculation occurs? (16-year-old boy)
9. Why do children avoid talking with parents about AIDS? (15-year-old girl)
10. Among our people (in Dondo) there is no talk between parents and children about sexuality. Why? (18-year-old boy)
11. Can a pregnant woman have sex? (16-year-old girl)
12. Should I share meals with someone infected? (16-year-old boy)
13. Do tuberculoses have a cure? (16-year-old girl)
14. Can a healthy person have HIV virus? (20-year-old girl)
15. Why do some people have unprotected sex with their girlfriends after having been tested HIV positive? (20-year-old boy)
16. Why do HIV-positive men use virgin girls to heal their diseases? (17-year-old girl)

Each concern presented above, varying from the origin of HIV/AIDS, its meaning, transmission, impact, prevention and behaviour hindering prevention intervention strategies, treatment and cure, education and other social related issues, were what the children asked. They asked these questions as a way of verifying the knowledge that they have from different spheres of the society.

Each of these spheres have different views. Churches believe that the God is angry with people for going against his commandments. These interpretations have a negative impact on the current HIV/AIDS prevention intervention strategies. Local people, traditionally do not value the use of condoms because they do not see it as part of their local culture. Furthermore, local people do not have trust to practices that are interpreted from the biomedical point of view. As a result, negative stories about condoms have been created. Some people believe that condoms carry in them HIV/AIDS. They feel they are being misled by the western cultural practices. Churches, discourages the use of condoms. They argue that since people are not allowed to practice fornication, there is no need for a condom. A husband has to be faithful to his wife and vice versa. The same applies to unmarried individual people, as Christianity discourages sex before marriage. Therefore, there is no need to have a condom, although the current HIV/AIDS prevention intervention is dominated by the condom use strategy.

The local perceptions of HIV/AIDS cannot be overlooked; people believe that *phiringaniso*/AIDS is a mythical disease that requires not western or biomedical medicine, but African medicine that is provided in a ritual form. As a result, there is the belief that a virgin, because she is clean, has the power to heal these mythical diseases.

As a result, girls are kidnapped and raped with a belief of that a virgin has the power in cleansing *xirombo*. People believe that *xirombo*/HIV and *phiringaniso* are curable. Again, the HIV/AIDS prevention interventions made from the public or biomedical perspectives do not stand a chance against this local perception as people continue to use their local method to interpret the situation around HIV/AIDS.

It appears from the self-generated data questions among the school youth that sexual behaviour is not influenced by knowledge of HIV/AIDS. Young people know about the biomedical concepts, but the fact that there are different and sometimes conflicting information justify the behaviour behind the manner in which young people conduct themselves. Moreover, *kulangiwa* ritual discussed earlier was not substituted by any tool that could provide the same education taught in *kulangiwa*. Because of this reason, young people have no clue on certain issues that they would have learned from the *kulangiwa*.

The fact that children ask conflicting questions means misunderstanding or receiving inconsistent information. For example, young people have different conflicting information about condoms. The reasons for such conflicting knowledge about condoms demands further research study.

Another problem is that the public or biomedical information on HIV/AIDS is provided to the people through a standardised system of giving out information, without assessing the audience of or the culture of the local people. In other words, the approach has failed to consider the distance, the basic existing intellectual knowledge at local level, available local resources and material conditions which are meaningful in

terms of acquisition of new knowledge among the local people. A question such as “did our ancestors suffer from HIV?” and “what is the reason behind HIV/AIDS?” suggest the need for actions against HIV/AIDS from the local perspective, addressing the problem using the local methods of viewing the world. Education about HIV/AIDS does not take in account knowledge that was generated from other cultural practices. The consideration of these concerns is necessary to empower young people in HIV prevention.

The kinds of questions that students asked suggest how the students are not only creative but also their critical consciousness in their shared set of socially transmitted perceptions about HIV and AIDS prevention interventions within a physical, social and spiritual world, particularly as it relates to achieving life’s goals (Basch 1989). The students concerns confirm that there is a need of giving information or knowledge that is consistent with or using people’s and community’s cultural framework rather than only based on the western biomedical approach from which health and education programmes are planned, implemented and evaluated (Airhihenbuwa 1995). It is clear that the situation demands a rethink on the current strategies for informing or providing people with the knowledge on HIV/AIDS prevention. The concern seems to be obvious but they are complex since it means that there are gaps in terms of the language that is used in HIV/AIDS prevention interventions.

Culture is more complex and dynamic not only in terms of ethnic, nationality, religion and language, but also in terms of social, cultural and education background including multiple perspectives within and between individuals of the same community. The same individual may take on different culturally relevant roles or identities depending

on the situation. This depends on the ability to take perspective as facts through developing pattern for assessing these facts. This will provide a possibility to see positive implications on negative experiences from the people's cultural point of view.

The HIV/AIDS prevention interventions is not effective in Mozambique due to the lack of interactions among cultures and cultural practices, as a result, critical importance of cultural practices are not reflecting in the programmes. Furthermore, the environments for cultural practices are chaotic, due to the failure to addresses cultural practices diversity that shapes and nurtures the lives of people including how young people can develop themselves. Children are diverted to different directions and create their own sub-cultural practices which are often different from and conflict with both the dominant and the local cultural practices.

The youth in any society is the future. Children carry the legacy of their parents, and when they attend schools, for example, they attend schools with a vision for their future, and this future may differ to that of their parents. Picture, D portrays something about the future of the young generation and the role of the school is to give the students tools to be used in the dynamic of cultural changes without loosing identity.



Picture D: *Students at one of the secondary schools*

Because of the importance of the children in carrying the legacy of their parents, they are the core in preserving the culture and its cultural practices. Parents use their children to protect their cultural practices. The reason for protecting these practices is that the current generation link the current practices with the future generation and with a belief of that there is something tangible about their cultural practices that can benefit the future generation. Because of this reason, they would wish their children preserve these practices forever. This is the reason a community values young people for protecting their cultural practices in which they grow up.

Kulangiwa ritual is one of the cultural practices that parents wish their children practice and transfer to the forthcoming generations. But, the situation is not always favourable, because young people's cultural experience can reveal different aspects, as young people move out of their parents' house, they can become agents of positive change, or divert to certain unacceptable behaviour. *Kulangiwa* should be a programme that makes the most of the youth opportunities. This practice is a tool for both the current

and the future generation, and it can be used to promote opposition against harmful practices such as early marriage and use information and communication strategy to promote development and encourage young people to participation in HIV/AIDS prevention intervention strategies. *Kulangiwa* is crucial and should be incorporated into all development-related policies and programmes, especially in areas like sex and sexuality including HIV/AIDS prevention interventions. Bringing in cultural practices would assists in all levels of society and all communities and groups to make prevention interventions principles according to their cultural practices that are part of their cultural value system. The HIV/AIDS prevention interventions should accommodate everyone and this can be made possible when individuals and communities find ways to articulate cultural practices in terms of their own cultures. HIV/AIDS prevention interventions should emerge from local cultural practices and can be effective when their strategies are well integrated to locally and when initiations for prevention interventions that come from the communities themselves.

Kulangiwa, like any other cultural practices, are inherited patterns of shared meanings and common understandings; it influences how people of Dondo and Maringue manage their lives and how they interpret their society. Cultural practices are subject to change, although within each cultural practice there are groups or individual people with distinctive sets of behaviours and beliefs that set them apart from the larger cultural practices. The practices are socially constructed and can bring about change that allows the articulation and realization of community values and practices in line with advanced society. Cultural practices change and are adaptable to the factors that can make an impact on societies and environments. They adjust values and behaviours in order to deal with the current situation.

Once a child fall out of the guidance of parents, in terms of thinking capabilities, the identity of that particular child is reconstructed and redefined. When children get exposed to certain environments like schools they acquire knowledge and responsibilities to become the member of that particular institutions, and because of this adaptability, they are able to draw a line between the school and their homes. They also recognise that the rules that influence the two institutions are different or similar and therefore adjust according to the rules of a particular institution. The burning issue is that each sphere has influence and this influences individuals differently. This is the reason young people do not share reminiscences and experiences with their parents; they develop their own ways of perceiving, appreciating, classifying and distinguishing issues along the way of learning new things and meeting new challenges.

The factors that influence cultural changes have equal influence to young people. Young people are as diverse as their societies and they live cultural change with more force than their parents because of the activeness. Their behaviour against cultural practices are visible because their actions have potential to change the cultural practice environments, which parents can take as an offence to their customs and this give an opportunity for young people to influence change in the environment. Therefore, HIV/AIDS prevention intervention strategies should accept the cultural practice framework of local people and work in partnership with them. This is important for local people especially young people who are falling in a trap of getting HIV/AIDS due to their irresponsible behaviours. Working with youth from their local cultural practice point of view in conjunction with the HIV/AIDS prevention can promote awareness

against the pandemic and change the current behavioural practices. Young people can reduce irresponsible behaviour that exposes them to risk sex and sexuality practices.

CHAPTER VI: HIV/AIDS PREVENTION INTERVENTIONS WITHIN THE CONTEXTUAL REALITIES IN DONDO AND MARINGUE DISTRICTS

Issues around HIV/AIDS in Dondo and Maringue are quite complicated. A number of issues raise not only complications but also a discourse that requires serious attention. HIV/AIDS exists but at the same time does not ‘exist’ among the local people in Dondo and Maringue what really exist is *phiringaniso* and *xirombo*. Different interpretations are available for people to make sense of their daily experiences. From an individual’s perspective, HIV/AIDS should be a concern of public health, or everybody’s concern despite their position or status in the society. Stories about the existence of HIV/AIDs are running around in the minds of the people, challenging people to think and make their own judgements about the situation. However, some people do not believe that AIDS exists, or exists as a cooked-up story. To those who believe in the presence of the disease, HIV/AIDS is meaningful when tackled from the western biomedical perspective. For others who believe that HIV/AIDS is a disease with local meanings, it is meaningful when tackled through local cultural concepts and practices. In addition there are people who believe the disease can be tackled from both western biomedicine and the local cultural perspective. This chapter addresses the manner in which HIV and AIDS health prevention interventions are organized as well as interpretation of the situation from the community members including teachers, students, community leaders and people living with AIDS. In order to demonstrate this, the chapter begins by presenting the experiences observed during a mobile film about HIV/AIDS. The mobile film was used for educating the public about HIV/AIDS in different places of Mozambique, including the study area. The story of the mobile film

illustrates the manner in which HIV/AIDS prevention interventions are organized in the country as well as in Dondo and Maringue.

The Mobile Film Show in Maringue: HIV/AIDS messages or entertainment?

One evening in 2008, a mobile film show was presented at Maringue Township and administrative headquarters, where there is the central market of Maringue District. This film was a programme initiated and facilitated by the Mozambican government in collaboration with the Italian government aimed at informing people about HIV/AIDS prevention and other sexually transmitted diseases.

This film show was an event that was hosted in different parts of the country and was part of an educational campaign to target people living in remote places. In Mozambique, these are areas where people do not have access to information through normal communication channels such as the radio, television, newspapers, etc and Maringue is one such unfortunate area. People travelled close to 15 kilometres to the local central market where the film was to be shown. In the market all kinds of merchandise was sold. There also were the *barracas* specialised in selling alcohol, food and some of these *barracas* had rooms for renting to those who want sex. The mobile-cinema thus presented to the people the ‘realities’ of HIV/AIDS in form of drama and music. Both the music and drama were produced in Maputo in Portuguese. Even though Portuguese is medium of communication in Mozambique, not everyone, however, speaks it as about 55.2 percent speak Portuguese. In Maringue, only 8 percent of the population speak Portuguese.

People walked long distances from their villages to the cinema which started much later than the planned time. Children who were already tired from the long walk, for example, fell asleep before the film started. Older children who were not under the supervision of the parents could divert from the cinema to the places of their interest, like meeting their partners, and visiting *barracas*. Some of these children spent the night in sheebens. As a result not every one got an opportunity to watch the film about general social issues, deliberating health and environment issues where HIV/AIDS stories were central.

The procedures raise questions on what the event brought to the people, especially to young people. The event was to inform people about moral behaviours that would help them avoid risky sexual practices that can expose them to HIV/AIDS. Instead the event became an opportunity for the children to expose themselves to behaviours that could lead to the risk of being infected with HIV/AIDS. Moreover, children walked the same long distance back home at late hours without supervision from parents. They got freedom to access and enter areas that they are normally restricted. The situation was similar for women who travelled alone to and from the cinema without protection, and therefore, risked being raped on the way.

It is mentioned above that the films were produced in Portuguese, but actors occasionally expressed themselves in local languages such as Xironga and Xitsonga. Different topics such as personal hygiene, cleaning domestic utensils, avoiding diarrhoea and cholera, Voluntary Counselling and Testing (VCT) and the need for condom use to avoid sexually transmitted infections (STIs), HIV/AIDS and sexual

harassment in the schools were presented. There was no doubt the film presented the stories with preventive messages for health and other social problems. The meaning of the message in the film was expressed through actions, conversations and music. The entire setting of the cinema/event was well designed, and had the potential to steal the minds and to touch the hearts of the audience. But it was unfortunate the stories were not initiated and facilitates from the local context and realities in Maringue. Rather, the dramas were imposing messages to the people just like any other movie on TVs, not to mention the limitation in the language used. As a result most people did not catch the message in the film.

In order to enhance interaction the cinema manager trained local theatre actors and the local leader as key informants and interpreters of the messages from the film to the audience. The actors were well known because they had been seen by the communities acting on local theatres, facilitating civic education programmes on early marriage and cholera. The community leaders were also trained on how interpret prevention in Sena language during the film. With the help of the local people the cinema manager and the staff mobilized the community members, women men and children to come and watch the film. The audience had opportunities to watch stories on HIV/AIDS and witnessed scary stories around behaviours and HIV/AIDS prevention. They witnessed demonstrations about cleanliness, hygiene, voluntary testing, condom use, cholera, sexually transmitted infections including HIV and AIDS.

Language is power as it has the ability to influence the conduct of an individual. It is also symbolic and material (Smith 1986). As presented above, not everyone in Maringue speaks Portuguese, and not everyone had the opportunity to understand the

message in the drama. In my view, it would have assisted many people in the community if behaviour in their community was expressed in a local language.

Some of the behaviours presented in the film were however similar to those practiced locally. Stories presented similar ‘realities’ as experienced by the local people. They saw partners in dilemmas, refusing to test themselves in order to find out their HIV status and even when their partners are HIV positive, they nevertheless decided to hide their health status. They also saw people who refused to build toilets for their families, arguing it was not necessary because there was enough bush for people to help themselves. Other than the hygiene episodes, the film presented people who thought condoms are infected or carry in them HIV and those who thought it is not necessary to use condoms. Stories about female school students who were seduced and forced to have sex with teachers in exchange for better marks were also presented. The event provided a moment for people to meet each others. In spite of this, the people were at the same time unhappy, because the dramas were not initiated from their localities. If they were initiated from their localities they would have the opportunity to be portrayed meaningfully on the big screen.

According to the cinema manager it was planned that the audience would have an opportunity to discuss the film. However, there was no time for such discussion, which would have clarified many issues and questions for the audience. People complained that they were called for nothing, because they did not understand what was being presented before them. The programme was good for those who could speak and read Portuguese, and more or less good for those who can interpret the meaning of the message through image. The community was disappointed because there was no

possibility of a repeat show and even if there would be a repeat, language was a barrier. The manager explained and said that it was expensive to present it again and also because it was a countrywide programme that they had to give opportunity to other parts of the country to view the film. As it often happens in media messages, most people silently concluded the meaning of the stories from the film, according to their own interpretations.

The film shown had a very top-down approach. The film had a way of informing people about HIV and AIDS, rather than allowing or involving people in creating the drama and the messages. Lack of participation and top-down approach is central in this thesis. The procedures taken in the hosting of the mobile-cinema event demonstrates the basis for 'resistance' or the reason why people partially accept or reject the biomedical interpretation of HIV/AIDS prevention. It is evident that people are aware of the HIV and AIDS activities where prevention, care or treatment take place in the study area as Caldwell (1999: 242) argues that, "Indeed so deeply has HIV/AIDS information penetrated that most Africans know a good deal more about it than about other sexually transmitted diseases (STDs)".

People have not accepted the whole biomedical prevention package. There are those who, for example, react against condom use because of a number of reasons. While some just do not want to change their sexual behaviour, others believe that prevention messages are against their cultural values. This is to say that the biomedical approach 'looks down on the local cultural health approach'. From the western perspective, it sounds dangerous to accept the local practices which give the impression that HIV/AIDS is curable is demonstrated in the ritual process for phiringaniso and

xirombo. This is a challenge that implies the need for interventions to apply different cultural perspectives to enable the people make informed decisions in their daily lives. The interventions stress the use of condom, but this does not address people's local realities. Moreover Christian religious groups advocate that people should be faithful to their partners and condom use should therefore not be necessary. HIV/AIDS prevention messages are neither compatible to the local cultural practices nor to the churches. The reason for the mismatch between the approaches is that the HIV/AIDS prevention interventions focus behavioural change in an individual forgetting the individual is part local context (Pisani 2008) as demonstrated by the socio-ecological theory approach.

It was discussed in the literature review that in Dondo and Maringue there are many actors in the health sector including NGOs that deal with general social issues, healers as health actors, organizations for people living with HIV/AIDS as well as community leaders and the media, mainly radio and TV that play a crucial role in sending prevention interventions messages. Apart from healers, the interventions in Dondo and Maringue do not take into account the traditions that are part of the people's daily lives.

The government view the continuous spread of HIV/AIDS as resulting from multiple sexual partners and unsafe sex practices; meanwhile the government and the media play double and conflicting roles. With the perspective mentioned above that HIV/AIDS spread result from unsafe sex, government and the media discourages the behaviour of multiple sexual partners, but fails to control prostitution and sex working. The media facilitates multiple sexual partners because of its presentation of stories that

are sexual, and therefore act as advertisement for prostitution-related services. There are no measures taken by the government to control *baracas* and other entertainment places where people are encouraged to practice unsafe sex.

The national media communication including the TV was described in this study as spending much time showing fashion like '*tchuna baby*,' a trouser that exposed the upper parts of the buttocks. Although it is wrong to say that women are responsible for men's sexual behaviour, in a patriarchal society, it gives people opportunities to see or to blame women for being responsible for men's sexual behaviours.

Some activists, who present the biomedical interventions as the correct way to tackle HIV/AIDS do not take lead by example as their behaviour conflicts with their messages. They socialise in the very environments considered to be central in exacerbating the spread of sexually transmitted infections.

HIV/AIDS prevention approach advocates faithfulness to one partner or reduction of the number of sexual partners, delay of the sexual debut for young people and condoms use. My argument is that this approach advocates a new cultural pattern in terms of behaviour among people. The reason HIV/AIDS prevention interventions focus on the behavioural change is that the current behaviour is accused for fuelling the spread of HIV/AIDS. The proposed behaviour is a challenge to the local people as it generates cultural conflicts. In order to have effective HIV/AIDS prevention, the universal or formal public strategy must accommodate local approaches. Such recognition and inclusion of local approaches would give people opportunities to rethink from their

own perspectives, effective measures in dealing with local health issues that considered, to fuel, the spread of HIV/AIDS.

From the local point of view different aspects that have an influence on the spread of HIV/AIDS include issues like:

- the government-blamed promiscuous behaviour and cultural practices;
- lack of observance of cultural practices (e.g. moving away from traditions),
- youth accommodating promiscuous behaviour,
- government sending mixed and conflicting messages and not controlling media in particular TV on entertainment programmes. While on the other hand government recommends faithfulness, condom use, and delay in sexual activity initiation, fidelity to one partner, and prevention from parents to child, taking anti-retroviral among others while from community apart of apart of government exigency they also observe traditional practices.

The use of resistance and socio-ecological theories were thus crucial in inquiring into the reasons for the failure of the HIV/AIDS prevention interventions. As discussed in the theoretical framework both the resistance and the socio-ecological theories were inspiring in understanding the holistic approach, paying attention to interpersonal, organizational, community and public policy is needed for assessing factors that support and maintain unhealthy behaviours (Glanz et al. 1988:351). The ecological perspective assumes that changes in social environment can reproduce changes in individuals' behaviour and the individual can change the environment. In the context of this study the term resistance relates to the covert/hidden rejection of biomedical interpretation of HIV/AIDS prevention interventions. From the biomedical point of

view, local people apply the theory of resistance where *xirombo*, and *phiringaniso* health/HIV/AIDS concepts and *kupitakufa*, *kupitamabzwade*, and *xitonga* rituals and other cultural practices are continuously practiced instead of biomedical medicine.

Meanings and Perceptions of HIV/AIDS Prevention Intervention

In Dondo and Maringue findings from different stakeholders demonstrate an understanding of how to prevent infection of HIV from both biomedical and cultural perspectives. Moreover people make obvious and critical view that they have knowledge on how HIV/AIDS preventive activities are implemented in the communities as they also identify the discrepancies between HIV interventions and the local cultural knowledge, local practices and rituals that require sex without condom, traditions and silences that culminate with intergenerational conflict.

Different Views and Risk of Infection

In Dondo and Maringue, during the interviews with key informants, group discussions, research participants and informal conversations, people expressed different views on the risk of infection. But they all agreed that sexual intercourse with multiple partners without *jeito*²⁷ (condom), exacerbated the spread of HIV. During the group discussions every person tended to emphasise behavioural changes, for example, being faithful to one partner as the means of prevention. Prevention messages are pasted in posters around the streets reminding people about their responsibilities around sexual behaviours and the risk of HIV/AIDS. Local and international NGOs have been intervening on HIV prevention knowledge. People in Dondo and Maringue pointed out

²⁷ *Jeito* is the Portuguese word for a condom.

that the increase of HIV cases resulted from disrespectful behaviour against customary practices, for example, new practices like young girls marrying older men and people looking for sexual pleasure out of wedlock. These people asserted that females, particularly young girls, are at higher risk compared to men because they marry older men as one informant stated:

Girls are at risk because of the marriage preparation that is being practiced among the local people. Girls do not have an agency in marriage. A man asks the family of a girl if he can marry their daughter, and if the family accepts, the girl does not have a right to refuse. It does not matter whether that particular man has multiple sexual relationships. The girl must act according to the wish of the parents, marry that particular man, and this means the girl is exposed to the risk of HIV. The problem is that people no longer apply traditional customs for assessing situations. Those traditional customs could check if the relationships would expose both the bride and groom into risky situations. People just create relationships and proceed with lives, but in the later stage of the marriage, reality catches with them. The same applies to boys who have sexual intercourse with older women since they cannot assess the situation as their focus is to get money from these old women. The environment is complex and chaotic and it is not easy to reverse the situation back to its origin. An older woman sleeping with a boy 'young enough to be her son' is a serious offence in the local tradition and a lack of respect to the people. The reasons for the large numbers of death from HIV/AIDS is because people have turned against their traditions, they make decisions without assessing their surroundings.

Adultery was described as an issue that is common even among Christians. Other than the traditional leaders and individual members of communities, the argument against the use of condom is central among religious groups. Condom use is not just discouraged among members of the churches, but also non-church members. It is argued that a husband and wife should be faithful to each other and that people must not get involved in extramarital sexual intercourse which also means that there is no need to distribute condoms. This logically explains that the prevention campaigns on condom use exclude a number of social groups with potential to make a difference in the society in relations to the fight against HIV/AIDS. The fight against HIV/AIDS can be made successful if the excluded social groups be involved in the campaigns as one informant argued:

If one can look at what different theologies say about the relationship between a man and a woman; a woman has to respect men, not only her husband, but every man. The same applies to a man; he has to respect every woman. Adultery is not allowed, the problem is that a human-being is a difficult animal to deal with. Some people are controlled by their emotions and feelings, not the other way around. Look at what is happening between the married couples; they are destroying themselves because of these extramarital relationships. It is not only non-members of our church, but everyone. It is just that this is embarrassing when it is done by the member of our church... (A school teacher in a group discussion, April 2007).

Some religious groups claim that they can cure AIDS through faith healing. These claims are challenging to the HIV/AIDS discourse, especially to the biomedical

approach. The various discourses of HIV/AIDS have resulted in confusion. While claiming that AIDS can be cured, others still question HIV as the cause of AIDS and the reality and existence of the virus. Apparently the environment has not just been about the fight against the pandemic but more significantly also the competing discourses that pull and push people in and out of different beliefs and approaches, as the above teacher continued and argued:

.... churches can cure AIDS. I heard from radio that three people were cured from AIDS, while we refer AIDS as an incurable disease. So they got cure from Universal Kingdom Church. So I remain without knowing if the disease really exists or it does not.

Education Policy in the Context of HIV Infection

The education policy was also described as one of the problems that lead to increase in prevalence of HIV in Dondo and Maringue. Some people believe that condom-use promotes promiscuity among young people and as young couples develop 'trust' they start to have sexual intercourse without condoms. This has resulted in a number of single mothers. After having children, these young or single mothers engage in unsafe sexual practices. Parents are not actually against condom use as they accept condom use to prevent the spread of HIV. What they oppose is the use of condoms among children because acceptance of condom use among these children is viewed as the approval of premarital sex.

Girls who fall pregnant are allowed to return to school after giving birth and this was said to be another reason for girls' negligent behaviour. Girls do not only run the risk of being infected, but they also become a vehicle of spreading the virus. It was said to be a usual practice for girls to have sex with strangers to earn money to support their children. In this sense, the people of Dondo and Maringue argued that the education policy on promotion of the condom use allows students or young people to have sex at anytime they wish. The parents and teachers disagreement on education HIV/AIDS policy is apparently more complex than it appears because it cannot be seen in isolation with other factors such as social and economic that take people make wrong decision among them and among them with children. People had found themselves between conflicting ideas. On the one hand, they argued condom use exacerbated the spread of the diseases. On the one hand they are convinced that condoms encourage sex before marriage but on the other they believe that condoms can help children avoid getting pregnant, as one teacher said:

.... I think that some of the government policies are against what we think as teachers and as parents [...]. In the past it was rare to see a student being pregnant at schools. It was not allowed that a child fall pregnant....Now that young people have 'rights' they make babies and come back to school. We do not even know how to treat a child who is a mother. She is our child but at the same time a wife to someone and that places us in a difficult situation. We must respect this kind of person. Some of these people take advantage; they misbehave knowing that we do not have better approaches to discipline them as we are disciplining our own kids and a wife to someone. They are adults, what must we do in this kind of situation?

Some students terminate pregnancy and then come back to school. There are many

prevention methods, but here at school we only focus on condom use. We say “be careful, use condoms”. In other words, we are indirectly saying you can go and have sex before marriage, but do it with a condom. This is the reason boys are able to have multiple girlfriends.

The above statement indicates that although education policy promotes condom use, the girls still engage in risky sexual behaviours and get pregnant that could be prevented by condom. Furthermore, people still have sex with multiple partners, and this multiple relationships create sexual networks that generate multiple risks to people. Although people have knowledge on HIV and AIDS, there is little evidence that they have changed their behaviours.

In this study, the teachers as parents indicated that it is hard to work on prevention at school without a proper education policy. Young people are influenced by different and conflicting approaches which complicate HIV prevention interventions as one of the teachers stated:

...HIV/AIDS is too complicated and confuses everyone, including our children who are the future of our society. At school, a teacher will teach Maria “A, B, C,” (referring to the formal education programme, including HIV programmes). Maria is meanwhile receiving informal education from her parents and from the peer about AIDS. Tell me, which approach should a child believe—the formal education or that of the parents or hearsays from the street? Let us face the fact prevention cannot be tackled from the formal education only. It must come from every angles of the society, and this can be made possible if each angle is in par with other

angles. We need to involve everyone. Today Maria will learn this and tomorrow is a different story for her. Which version is correct, maybe all the versions are correct but using different routes to a single point or destination.

The teachers suggested the need to harmonise and exert more control on what and how information on HIV prevention is delivered. This was one of the reasons one member in the group discussion criticized the manner in which some of those working on HIV/AIDS prevention fail to consider the differences in age groups when they deliver prevention messages. Meanwhile, children have a tendency to imitate what the adult say or do. As a result children want to experiment what is being taught and consequently they get infected with HIV. One of the members argued during the group discussion in the following way:

...activists cannot talk about HIV/AIDS without talking about sex and it does not matter as to who they talk to. The messages that they send to adults are the same messages that they send to a 7 year old child ..., sorry about the language, they normally use wooden penis to demonstrate sexual intercourse and say, “when it becomes straight you must introduce a condom” how can one say such words to kids. Children, as a result experiment and they experiment with or without a condom. Some of these children end up advising their friends that they prefer having sex without a condom so their friends must try. This behaviour is a kind of experimentation of new things in life, and this creates habits for hating the use of condoms. As a result children get AIDS and die at early age. (April, 2007)

According to the community leaders there is a need for reintroducing the lost cultural practices such as *mafungo* (initiation cultural practice) which as one of the teachers argued that:

....educate our girls and the organizers of the HIV/AIDS prevention programme must work in collaboration with elders especially in the context of initiation rites like '*safungo*' that sensitize girls. This will help girls to stop bad behaviours like walking before parents wearing mini skirts and exposing their buttocks. Nowadays parents have no power to control and educate their children, because children view parents stuck in old ideas. This is a failure to see that they die at early age because of the failure to listen to their parents.

During the group discussion, with healers, the issue of TVs' influence on young people was raised. They referred to Brazilians and Portuguese stories that teach children lifestyles that are not acceptable among the local people. They argued that the stories present before children behaviours that are against the norms of their culture. Some of these programmes are embarrassing for children to view in the presence of parents and vice versa, as one of the members of the community argued:

TV programmes are always out of order, they broadcasts stories that involve sex during inappropriate hours. It is risky to watch TV with visitors, because at any time, sexual intercourse is presented on TV. If you dare switch on your TV before relatives or children, you just want to embarrass yourself.

The teachers also described media especially TV as a problem because of its influence on young people as argued below:

...AIDS in Mozambique is related to fashion. We watch our television and the first thing it shows '*Face VODACOM*'²⁸ and '*Loja das Damas*'²⁹ programmes. Frankly, what are they doing on television? It is a shame, because it looks like the managers are promoting behaviour that contributes to the spread of AIDS. I was embarrassed to see naked women on television; walking around 'naked', "dgica dgica"³⁰. They wear those trousers, what do they call them? '*Tchuna baby! yes tchuna baby*'. People, especially young girls copy what they see on TV. What type of a man resists a girl showing everything? When you see female intimate parts you forget that AIDS exists. (Group discussion with teachers, 2007)

TV is seen as promoting free sex, alienating girls and exposing young children to sex. In their view, TV has influence on the way women dress which then influences men's behaviour. Since gender and culture have emerged as two key issues in the health status of women and men, it also has influence on inequalities in health. Thus, gender has an impact on health and illness and shapes women's and men's choices and expectations, including behaviours that expose them to various risks including infection with HIV. Although gender is more than sex, in this context it refers to female or male, it is also related to sexual activity, desire and fantasy. However, as socially constructed, it is an internalized view of women and men that shapes their

²⁸ *Face VODACOM* is a modelling programme on the television.

²⁹ *Loja das Damas* is the name of a local women clothes shop, very famous for the sale of the *tchuna baby* trouser.

³⁰ *Dgica, dgica* means walking around in Sena.

identities, perceptions and behaviours. It allocates social power, privileges and access to resources, but also plays different roles in different contexts and circumstances. Thus, blaming women's dressing as the source of HIV transmission can be understood from a gender perspective, where power relations are the issue. Some teachers expressed their concern on use of dressing code to protect people from infection with HIV. One teacher in the group discussion argued:

We have our HIV/AIDS programme coordinator, who guides students on how they should behave, including dressing codes. Dressing code is very important and form part of education, but students do not want to take advice. This is a challenge that needs to be addressed adequately. Child protection AIDS policies that are aimed at mitigating the effects of AIDS.

Blame on Women's Dressing Code

The issue of dressing reflects gender inequalities as illustrated above where the manner in which female dressing code is seen as being suggestive of availability of sex for men. According to the teachers and some parents, prevention should be directed at women, because those who dress badly need to be controlled or punished for their bad behaviour. Dressing codes are linked to the age when girls engage in sex. This puts parents' especially poor parents under pressure as indicated below:

Historically in our culture women wear long dresses as a way of showing respect, and they had to remain at home, because a women's place is the home. The behaviours we witness today are not part of our tradition. Women and young girls

wander around the streets looking for entertainments and for pleasure. These types of women do not respect themselves, their partners and their families. They turned the society upside down. It is new that girls start sex at an early age, this was not our reality. From my observation, there are male students, who are 13 to 14 years old but do not know a woman yet. But women start earlier due to pressure from some parents who are poor. Some of these behaviours are encouraged by fashion shows in television. (A male person and a member of a community)

Economic power was mentioned by the community leaders in this study as another reason for getting infection. They argued that economic status encourages men to approach beautiful women, especially women from Beira. Moreover, the community leaders blame men for failing to support their own wives, as indicated in the conversation bellow:

Interviewee (a male member of the community): It is not only women who are engaged in provoking men for sexual intercourse? Men too, are failing themselves, we are not able to resist these women. Our local men visit Beira to meet these beautiful women. But these women are not free, you have to pay cash. We pay cash for our failure to make our wives beautiful.

Interviewer: why don't you dress our wives well so that they look beautiful like women in Beira?

Interviewee: yes, it is our fault that we do not dress our wives very well. We leave them in *capulanas*, without changing their dressing styles.

Interviewer: Is it true that you hide money from your wives? Why?

Interviewee: We have been taught by our parents that a man must support his family, but this does not necessary mean my wife should not be part of decision-making, for example on what to buy and what not to buy. Some men feel that if they manage to buy all what their families needs why should they give or show their money to their women. Their behaviour gives them opportunities to use their money for personal pleasure. They go to town and use this money to “*gingar*”³¹ to the girls, that they have enough money.

Interviewer: So how does this relate to HIV/AIDS?

Interviewee: Economic status contributes to the spread of HIV/AIDS, not only to those who are after money, but also to those who use money to access multiple sexual relationships. (Group discussion, 2008)

The above discussion demonstrates how men construct the body of a woman, and how the body of a woman stimulates risky behaviour towards sexually transmitted infections including HIV. However, the notion of body varies across different cultures (Kowner 2002). In Maringue and Dondo men are concerned with the women’s body image in relation to their dressing style. According to these people, it is a women’s body that increases infection, and this is accompanied by the economic status that provide access to multiple sexual relations. However, they blamed women as responsible ‘for the men behaviours’. Again the community leaders argued that government is failing people, because it did not regulate the manner in which people dressed. People can dress in any ways and expose their private parts. One of the

³¹ *Gingar* is a Portuguese word that means walking with the nose on high or looking down to people of lower status.

community leaders suggested that the government must regulate dressing styles by introducing dressing codes:

We leaders have to think about our children especially girls; we need to solve the problem of mini-skirts. Because of wearing mini-skirts our girls attract men and expose themselves to risky behaviours. If the government can introduce regulations that prohibit women to dress in mini-skirts, we would minimize the transmission of HIV/AIDS. This freedom of mini-skirts is a big problem, because many of our school girls have forgotten that they went to school for education not to expose their thighs from school shorts uniforms skirts. They must know that they went to school for education not for something else. They have to respect themselves and respect men. They must wait until mature stage and get married according to our custom. Their time will come when they can engage in sexual behaviour legally. (December, 2008)

In the context of visual means of communication the community leaders in Maringue discussed the impact of videos on people. Although Maringue does not have electricity, movies are shown to the local people in public spaces. The public film episode described at the beginning of this chapter indicates the impact of such shows in public lasting until late at night. Young people can use such occasions as a way out of their homes to meet their partners. This moment of public video interfere with parental control over their children.

The challenge of HIV/AIDS around youth demands sharing responsibility between the parents, teachers, and everyone that plays a role in raising and socialising a child. The

community perspectives in this study were that video, TV and other media influence goes beyond the dressing code. The language that is used on media does not take into account the issue of respect. Some words used in the media are not acceptable and this represents cultural clash among social actors, especially between old and young generations, as one teacher argued: “As I was telling my colleague even here at school we have done some work, and when we become strict they say you are ‘*matreco*’³²” (Teacher from school, 2007)

Young people use the word *matreco* to refer to declining advice from adults. However, *matreco* in the social context is viewed as playing a significant role of removing power from adults to youth (in this case the power of teachers and parents to children). Walking, dressing styles and language use have become means of distinguishing between a *matreco* and the new generation.

The challenges for the communities in dealing with HIV and AIDS become extremely critical. Professionals working with HIV/AIDS are seen as more concerned with their own individual needs rather than being concerned about the community. The community criticized NGO coordinators for misuse of funds from the National AIDS Council for AIDS activities. According to some community members, AIDS has become an industry for profit-making for some people and organizations. Money meant for HIV/AIDS prevention programmes is stolen by officials for their personal gains. Furthermore, the money was said to be spent on girlfriends. This means that those advocating for prevention through sexual behaviour change are the same ones contributing to the spread of HIV infection as elaborated by a teacher:

³² *Matreco* is a Mozambican term used to describe a person who is old-fashioned.

....the HIV/AIDS policy is not effective because many organizations dealing with HIV/AIDS are not serious. The managers in these organizations receive money from the National HIV/AIDS Council (CNC), but they use it for seducing girls. They usually come here driving nice cars they have bought with the money budgeted for HIV/AIDS programmes. This is witnessed all over the country. They use that money to open their own companies. Nowadays working for AIDS organizations is a new way of making money in Mozambique. (April 2007)

According to the people in these communities HIV/AIDS programmes should be included formally in the education policy. The programme should not only be included in academic education programmes, but be initiated from homes, where parents, as well as other community organizations, are concerned. In order to make HIV prevention interventions effective, the teachers said interaction with different actors is required and that the responsibility of educating children should be shared. They argued that support of children is too complex and that HIV/AIDS prevention interventions are difficult because people have their own prejudice and limitations. This is the reason why there are contradictions in approaches and practices of people from the same village. According to the teachers, HIV education for young people should not be left to schools alone. It should be shared, because part of socialisation process takes place at communities as one member argued:

Communities must help educators, because the schools alone cannot educate children. ...The society accuses the schools for not educating children. People say that students spend much of their time at school; therefore schools should be

responsible for educating children about AIDS. No... responsibilities cannot be left to schools alone; the society at large should be responsible. It is the society that has the influence in the manner in which children behave. It is the responsibility of the entire society that children wear “*chuna babies*”. (October, 2008)

HIV Infection and Culture of Silence

The culture of silence is an issue raised by students during group discussion. They argued that silence creates communication gaps between parents and children. The adults expect children to act upon advice from parents. In the context of AIDS, this is intricate, because there is no room for discussion or interaction between parents and children, for children to get advice from parents and to raise questions regarding the issues that concern them. For example, sex and sexuality in the context of HIV/AIDS and in relation to cultural practices such as rituals of cleansing as one student stated:

Young people are of the view that cultural ritual (referring to *kupitakufa* and *kupitamabzwade*) performances are meaningless. The problem is that our parents are not educated and we do not trust their knowledge. They need advice from their educated children too. Even if we trust our parents’ advice, it is difficult to break the silence because of the limited interaction between parents and us. We are unable to advise our parents due to the fact that it is regarded as an offence if a child tries to question adults. (Student in a group discussion ,October 2008)

It is not only children who view silence as a bridge of communication between parents and children. Some teachers argued that children have difficulties in facing the pandemic, because the parents do not speak about sex at all.

However, silence is further complicated by the speculation on the foreign origin of HIV/AIDS. This confuses people who, therefore, conclude that AIDS does not exist. One member during the group discussion argued:

that the nature of the disease, and its long incubation, which is associated with trust and with the fact that the first individual identified as HIV positive in the country was a foreigner, make people to have doubts on the reality of AIDS.

This has created a discourse of blaming the foreigners and prostitutes. Furthermore, delays on the action against HIV/AIDS were named as problems that have led to the spread of HIV/AIDS, an attitude perpetuated when launching HIV/AIDS interventions.

From my point of view, the only problem that leads to the spread of AIDS is that people do not have doubt about status of partners; they lack doubt due to the lack of HIV/AIDS education. We hear people saying that medicine for curing AIDS exists, but is said to be expensive. Furthermore, we are unable to identify a person who suffers from AIDS. In most cases it is not easy to guess if a particular person is infected with HIV virus or suffers from AIDS, especially where there are no external signs. One would assume that if a person's physical appearance looks good, it means that the particular person is healthy, and so fall in a trap. People just

get themselves passports to death because of wrong assumptions. (A teacher, October 2008).

According to the teachers in this study, there is contradicting information about the spread of AIDS especially through media and gossip about the possible existing medication to cure AIDS. People in the community have access to anti-retroviral to strengthen their immune system and they survive although there still is no cure for AIDS. This is critical, because it becomes hard to convince people against what they think is false information or gossip about the pandemic:

....I can't remember now, but I heard this from different people that there are some countries that have treatment to cure AIDS, not for prevention, but for cure, and this information is disseminated and people are waiting for that medication, but the cure does not come to Mozambique. This is the reason we concluded that AIDS is a myth invented by some people in order to make money (A Teacher, November, 2008).

Inequalities in Accessing Treatment Resources

During the study, some people who suffer from HIV/AIDS were concerned about the anti-retroviral treatment, because it was not accessible especially to the poor. The health sector was not able to make anti-retroviral medication available to all those in need. Only a very small number of people could access this medication. According to people suffering from AIDS, the anti-retroviral medication was only accessible to the

rich people. According to some teachers and community leaders, the rich were the same people who coordinated the HIV/AIDS programmes and the same group benefiting from these programme. This was the reason people were not able to get satisfying answer from the health sector, and because of this situation, some people have doubts about the reality of HIV/AIDS as one of the teachers said:

AIDS in Mozambique came to make other people rich. AIDS affect poor people who cannot afford anti-retroviral. It is not easy to get their medication from the hospitals; people die on queues before they get treatment. The poor die from AIDS and the rich do not die, because the rich have access to the medication/ treatments and they also have to access to programme coordination... When a new programme gets implemented, the very same people are in front of the programme... and this happens because we are ignorant, we don't accept that AIDS is real. Meanwhile AIDS is a disease that is killing many people. It will not help us to ignore, we must accept that we have a problem that requires us to think and take actions (A teacher, November 2008).

The fact that the health sector is unable to deliver health services worsens the situation, and HIV/AIDS spread increases which in turn increases a number of deaths in the communities.

Meanings and Perceptions of Community Leaders about HIV/AIDS Prevention Interventions

Since community leaders are also caregivers to members of their communities by taking responsibility for activities in the community, it was crucial to understand their

perceptions HIV/AIDS prevention interventions. However, due to the fact that HIV/AIDS prevention interventions programmes are recent in Maringue, people expressed their views according to their own experiences and stories that are passed by mouth. NGOs, which are front runner in prevention interventions, were still few and those who exist, are struggling in terms of material and financial resources. During group discussions, I understood that some of the community leaders received information about HIV and AIDS prevention through the media. It was also evident that depending on the availability of resources, people were more informed of the reality. The most active HIV/AIDS activists are the religious associations like the Protestants and Catholic, because they have access to funds from their own funds, including external donors. These groups did not depend only on “*Conselho Distrital de Combate ao SIDA*” (CDCS)³³ funds, but also on other sources. The HIV/AIDS situation in Maringue was that there was a lack of consistent HIV/AIDS prevention. In some areas it was evident that interventions came directly from leaders, although it was revealed that discrimination among people living with AIDS is usual as one member of the community asserted:

If I were the government I would eliminate the disease by isolating infected people from the community. I would start in Maputo the capital of the country until every District in the country removes all those who suffer from AIDS, then enter Quelimane (the capital of Zambezia Province and Cabo Delgado the north Province) which is the northern limit of the country (Community leader, October 2008).

³³ CDCS means District Council against AIDS

The fact that AIDS is a disease that is perceived to have come from outside or being a disease of "*others*" makes people think that the disease is still a problem that comes from outside and there is still enough time to control it from penetrating into the country. Furthermore, as it is sexually transmitted, AIDS is always associated with those who have different sexual partners or those who are prostitutes or have sexual intercourse with prostitutes. In a focus group discussion, the community members involved argued that HIV/AIDS was spread by some professionals who always travelled around the country: "...AIDS could be reduced if the truck drivers who come from South Africa can be controlled". (October, 2008)

The spread of the disease is also seen as related to limited use of condoms by those who have multiple sexual relationships as one community leader stated:

Most of time, sra. Directora,³⁴ we discuss in the meetings that men must use *jeito* when they decide to have extra-marital sexual relations. But they do not listen. Many teachers are dying here because of AIDS. Where do they get the disease? You will never know, they might have got it from these school girls. This is true.

While biomedical approach advises people to reduce the number of sexual partners as a means of reducing HIV transmission in the community, people do not see this problem as relying on numbers of sexual partners, but in the manner in which relationships are practiced. They believe that people should test for HIV and use condoms if they get involved in multiple sexual relationships.

³⁴ The title, sra means Sir. The term Directora, means Director or a Manager

Other than the condom use, people consider HIV infection as the will of God because the disease is everywhere in the world as one of the parent argued: “We do not know, the disease might have been sent by God because it is everywhere, in South Africa and other countries. We might have been cursed by the God, because of turning against him.”

The Lack of Access to Information and the Increase of HIV Infection

The research participants pointed out that access to information resources is one of the reasons that limit knowledge on HIV/AIDS prevention. Limitation in knowledge is due to the interventions that are also limited. People did not get enough information about the HIV/AIDS pandemic and there were no proper forms of prevention. Thus people had difficulties in understand what was happening in their surroundings in order to understand why the same issues are approached in different ways. Different approaches depending on the type of an actor and available resources behind the prevention were made available to the local people. Thus where resources were more available, actions against HIV/AIDS was more visible and people were more conversant about different AIDS prevention interventions taking place in their local environment as one community leader stated:

....in my area there is an NGO that is working on the environment, making sure that we keep our place clean, including our houses and our own domestic facilities. Different group of people are competing on cleaning their places and domestic facilities: like building toilets and collecting garbage, and the best

group receive an award from the NGO. This is good, because the environment is changing and contributes to the life of the people. (October, 2008)

In support of the above another community leader said: “.... we have an NGO that is helping many poor people, mainly orphans, widows and elders by giving them food and supporting those families affected by HIV/AIDS. This NGO also assist people by promoting the use of condom.”

The distribution of condom is one of the preventive activities at the community level, and community leaders are responsible for distributing condoms in the community to prevent HIV infection as indicated in this statement: “...The health sector makes condoms available and gives us responsibility to distribute them in the community. But some people in the community leave condom with children who use or play with them as balloons.” (October, 2008)

At some stage there is an interaction among different actors such as those from health sector and from NGOs in the HIV prevention, although depending on the kind of activity. The fact that there are many different actors who are working on HIV/AIDS, make people get rid of the fear of AIDS. But what makes things difficult was the shortage, even the lack, of medication in the health centres and food for those who are unable to support themselves, as one of the activists asserted:

“People used to have a fear about AIDS, but today they are no longer scared and are able to consult the hospital for medication, but medication is not easily available. Although there are activists (who take care of people living with

AIDS) for example, in my *bairro*³⁵ who give medication, it is hard to get these medications. These people experience difficulties in serving our people who are suffering due to the shortage of medications in the public chemist. In most times people have to buy medication in private chemists. But the situation is not favourable to everyone since the majority of these people are not employed; they are just peasants who do not make money out of their subsistence farming activities. Another problem is that we do not have staff to feed people suffering from the disease, meanwhile in order for one to take medication and to allow the medication to be effective, that particular person must follow the medical practitioner's instructions and at the same time take a balanced diet. The health sector is not winning in taking care of people suffering from the HIV/AIDS disease.

From the people's perspective, the health sector has the responsibility for providing service to the people in a holistic way because HIV/AIDS is complex. There is no difference between prevention and treatment, because people are mainly tested only when they feel sick. From this perspective, to speak about prevention is also speaking about care and treatment. According to the community leaders, prevention messages should not be the only available information, it should include be about making sure that medication is available too. This is the reason why leaders complain about the health sector, because the health sector fails to provide medication and necessary care for HIV/AIDS. Furthermore, when people get sick they lose their capacity to manage themselves and their privacy is removed, because health service providers intervene in their private life. It is argued that in order to allow the medication to be effective, a

³⁵ *Bairro* is a township extension

person who takes this medication must take a balanced diet. Lack of food worsens the health conditions. Nevertheless the government and the donors are not investing enough to give support to people in need of medication and food, and this discourages people from consulting with clinics and hospitals for medical services or other services associated with this medication.

HIV Infection and Unemployment

Generally, unemployment is one of the problems that affect the whole country, although it is exacerbated in the rural areas like Maringue and Dondo. Thus community leaders are concerned because this affects mainly to young people. They believe that job creation would keep young people busy working instead of spending time in *barracas* and having sex with different girls, as stated by one of the community leaders during the group discussion: “It is necessary to create jobs for the youth. Carpentry and tailoring would keep them busy so that they stop going to the shebeens (*barracas*) and night clubs. This will keep them busy and occupied, therefore serve them from the HIV/AIDS spread....”.

It was asserted that shebeens are problematic and need to be regulated in order to create a certain discipline. Shebeens are seen as the promoter of prostitution, which thereby exposes people to the HIV infection.

There is a need to control people; people should be out of these places by 22H00 pm. After the hosting, the owners must close, but they keep them running for 24

hours. The '*barracas*' open until morning of the following the day. The problem is that there is no law to enforce this, they need to be monitored.

HIV/AIDS has the potential to destabilise the economy and erode the political and institutional capacity of the government and disintegrate socio-cultural systems. This means that HIV/AIDS challenges can fundamentally alter the nature of lifestyle and the development of the country. Although the political and economic dimensions are not a focus in this study, their relevance in this study is not overlooked, specifically the impact of the political and economic status on the spread of the pandemic. These are major issues influencing the spread of the disease and require further research. It was possible to identify the impact of the economic and political systems in Dondo and Maringue specifically on the decline in productivity among the people of Dondo, particularly in families hit by HIV/AIDS. The pandemic is likely to reinforce the negative aspects of economic change, e.g., unemployment, especially amongst people who suffer from the disease. The issue of changes in economic status to families hit by HIV/AIDS manifest itself especially when the sick cannot support themselves and their families.

A large number of young people were not employed in Dondo and Maringue; many of these young people were drop outs from school. This is a problem especially for parents who suffer from AIDS, because it is difficult to support their children while they are on medication. When parents die, they leave children helpless. The situation looks ugly to the orphans. As a result many of these children spend their times in sheebens taking alcohol and selling sex in order to support themselves and their siblings. According to Portes et al. (1989) and (UNCHS 1996) this kind of situation

stimulates the emergence of shebeens and street sellers that result in bigger socio-economic disparities and an increase of poverty. Poor households are more affected by HIV/AIDS morbidity and mortality when compared to the wealthier households, in terms of household income, expenses towards well-being of people infected. This means that a reduction of nutrition and an overall intensification of poverty and inequality.

The capacity of poor households to pay for service charge is jeopardized by the financial implications of HIV/AIDS at the household level. In the case of Dondo and Maringue community leaders find it difficult to help people who are sick or orphans. It is clear that an HIV/AIDS prevention intervention is a problem and it affects all the dimensions of the societies. It is difficult to approach HIV/AIDS prevention on the socio-cultural dimension without taking in account the material or economic resources and political strategies that are major aspects influencing decision makers, especially the socio-economic status of the families, particularly those hit by HIV/AIDS disease. These aspects are central in the HIV/AIDS prevention interventions and the contextual realities in Dondo and Maringue as this study aims to show are core determinants facilitating the spread of HIV/AIDS. The country still has a large number of people who are not covered by the HIV/AIDS prevention interventions. Because of this situation, the disease is predominantly defined as a health issue (Marais 2000; Van der Vliet 2001).

CHAPTER VII: INDIGENOUS KNOWLEDGE AND CULTURAL PRACTICES IN THE CONTEXT OF HIV/AIDS PREVENTION IN DONDO AND MARINGUE DISTRICTS

Although the public-adopted HIV/AIDS prevention is acknowledged in Dondo and Maringue, local cultural health practices are used in Dondo and Maringue. *Xirombo* and *phiringaniso* are the local concepts of HIV/AIDS. *Kupitakufa*, *kupitamabzwade*, *kupitamoto* and *xitonga* are used for health conditions including HIV/AIDS (*xirombo* and *phiringaniso*). The persistence of these cultural practices means that biomedical approach has little meaning to the lives of the local people and the HIV/AIDS prevention interventions have not been fully accepted in Dondo and Maringue. This thesis argues that the low acknowledgement of HIV prevention intervention strategies was due to the continued use of local cultural practices for dealing with diseases. The local cultural practices question the compatibility of the implemented HIV/AIDS prevention interventions at the local level. This chapter analyses the cultural practices in the context of HIV/AIDS prevention. *Xirombo* and *phiringaniso*—local medical concepts and *kupitakufa*, *kupitamabzwade*, *kupitamoto* and *xitonga*—local rituals practiced for health. These local cultural concepts and rituals have however not been recognised in the public health. This thesis argues that the incorporation of cultural health practices into the public health sector is needed as a method for dealing with health issues including HIV/AIDS prevention. Although cultural health practices were still informal in the public health, they are preferred among the local people and this has resulted in a conflict of cultures in society. The HIV/AIDS prevention strategies were adopted from the western biomedicine, while the local cultural practices were adopted from the local traditional culture. The two approaches crashed, creating a

conflict in health sector. The two approaches share a health concern, but they both use different methods and therefore have different impacts among the subscribers of these culture.

The reason for the preferences for traditional medicine is influenced by the people's faith in cultural practices. The situation does not only emanate from the faith in culture, but also from the dominance of the cultural health practices at the local level. The fact that people prefer the use of cultural practices means it is meaningful to them. The biomedical approach has thus bounced in dealing with health issues at a local level and this is one of the reasons this thesis suggests the incorporation of cultural health practices into the public health system as a way of stimulating people to fully recognise the value of both biomedical approach and local cultural practices.

The continuation in neglecting the cultural practices will mean that the public health system will remain ineffective as the current HIV/AIDS prevention interventions methods will remain incompatible with the local cultural health practices. People in Dondo and Maringue districts are able to use western biomedical ideology in interpreting HIV/AIDS prevention interventions although the influence of indigenous knowledge in the local health practice is still high. The use of indigenous concepts, such as *xirombo*, *phiringaniso* and the rituals such *kupitakufa*, *kupitamabzwade*, *kupitamoto* and *xitonga*, can be understood as a form of resistance against the western health ideology, which affect the effectiveness of HIV/AIDS prevention intervention strategies as it is clear from the persisting spread of HIV/AIDS.

In the current HIV/AIDS environment, realistic and challenging facts exist. In demonstrating these facts, a local health conceptual framework is discussed in the context of HIV/AIDS, including its implication to HIV/AIDS prevention. This conceptual framework contains theory and practice. The framework discusses the local concepts and practices (rituals) used in local health, including the functions and the meanings of the concepts and practices to the people. A conception of this theory (concepts) and practice (rituals) provide an understanding of how local people organize and make sense of their daily lives. This conception is a guiding principle in assessing the effectiveness in adopting HIV/AIDS prevention interventions that affect people at a local level, including decisions around health in general. Effective HIV/AIDS prevention intervention strategies would be made possible through the recognition of culture of the local people and where the recognition can be made possible through the assistance of people in setting their realistic criteria for evaluating their own cultural health approaches. The current situation is too complex and demands that the public/government allow people to assess their socio-cultural systems not currently accommodated in biomedical interpretation of HIV/AIDS prevention. To demonstrate this complexity, this study focuses on the meaning of sex and sexuality and the understanding of HIV/AIDS prevention interventions in the context of socio-cultural dimension among the people in Dondo and Maringue. In this study local cultural concepts as well as rituals are used to interpret the behaviour and local meanings to sex and sexuality, and disease, including HIV/AIDS. Local people conceptualise their socio-cultural sphere using cultural systems and practices and this helps them to interpret their daily activities and experiences. The health interpretations from local cultural practice differ from the interpretations that are coined from the western cultural perspectives. The ability of local people to interpret their socio-cultural

dimension differently from the western perceptive makes western biomedical interpretation less meaningful to the local people.

A number of cultural practices are still practiced among the people in Dondo and Maringue to fulfil different purposes. They range from rituals that address childbirth, sickness, death, a burnt-house, abortion, and other health-related issues including HIV/AIDS prevention. Although local health concepts and their rituals have same roots and meanings among different regions in Mozambique, they however, differ in names and performance processes (Altuna 1955; Bravo 1989/90; Dias 1964, 1970; 1966; Martinez, 1989). In this thesis, cultural practices are referred to as rituals because they involve ceremonies with supernatural powers that link people with the ancestors. Rituals are performed through certain activities with mythical powers that are translated into meaningful performance in a particular place or space (Delfin 1991). They sustain the relationships among the people and connect them to their ancestors. Rituals are claimed as events performed as requirements for fulfilling certain objectives where gestures vitally translate the significance of their performance into the lives of the people.

Description, Meaning and Performance of Cultural Practices Around Sexuality

Rituals are a form of negotiation of social and cultural differences (Bell 1977: 267). They are structured activities that take place in formal or 'sacred' spaces and they are recognised and used as approaches for cleansing. This is a perspective of rituals as religious practices. A ritual is however not just a religious performance. It is also any performance that reproduces and sustains social order (Barfield 1977: 410). This

includes human actions such as official parades, graduations in schools and universities or weddings as are meaningful to the people. In Mozambique rituals are a reality in people's daily lives. This thesis argues that rituals can be used as a framework that can contribute in developing strategies against diseases and HIV/AIDS in particular. Rituals have in them social and cultural meanings and for this reason, rituals are said to contribute to the spread of HIV/AIDS. at the same time they can also be used as a strategy for reducing the spread of HIV/AIDS. The *kupitakufa*, *kupitamadz Wade* and *kupitamoto* rituals can be significant in reducing the spread of HIV/AIDS.

In order to make sense of the above claims, the above rituals are discussed and demonstrate the meaning and the impact of a ritual in the lives of the people who subscribed to a certain particular culture, and the possible roles of the use of rituals in reducing the risks around the spread of HIV/AIDS.

Kupitakufa Ritual

Kupitakufa is a cleansing ritual performed by family members after death of a family member specifically a married person.

The mourning period is believed to be a polluted environment and dangerous for people to carry on with their daily activities. Krings-Ney et al. (2009:492) argue that "the objective of cleansing is to restore a state of 'coolness' which is necessary for people to carry on their lives in the community". The polluted environment is said to be dangerous because it exposes people to disease or dirt (Green 1999a, 1999b). The cleansing rituals are cultural practices meant for transforming people from one state to the next.

Kupitakufa ritual takes place 7 days after the death and the burial ceremony and the mourning proceed up until the thirtieth or forty-fifth day after the burial of the deceased. The widow/widower and the entire family are cleansed or purified from death after the ritual performance and days of mourning are over. The purification process embraces all the members of the community. Besides cleansing, *kupitakufa* is also a healing ritual as it is believed to have the powers to chase away *mbepho* and heal diseases related to cause of death in the family.

Kupitakufa is also important in giving permission to the widow or widower to remarry. Since marriage is viewed as an institution to legitimise relationships between people, among relatives of both the wife and the husband (Smith 1986:180), a person cannot get married, without permission from the family including ancestors. A widow or widower is allowed to get married after the *kupitakufa* ritual as well as given the inheritance of the belongings of the deceased. If the deceased is a male the inheritance includes his widow and children. The death of a person is believed to pollute everyone in the family and in the community. The cleansing ritual therefore allows the community to proceed with their lives including sexual practices. Before the *kupitakufa* ritual, no member of the community who participated in the burial is allowed to have sexual intercourse, and the prohibition extends to other daily activities. People are not allowed to be active in certain activities that involve digging the ground or touching soil for, e.g., agricultural activities. All activities performed between the death and before the *kupitakufa* are declared impure, because of the pollution from *mbepho* that brought death in the family or community.

There are two ways of performing *kupitakufa* ritual. One involves the use of herbs or medication. The other involves sexual intercourse. The herbal type of performance is called *xitonga*.³⁶ The results from *xitonga* process are believed have same meaning or equal impact to that of the sexual performance. The herbal type is accessed from the healers and can be used in the following three ways:

1. All members of the family bathe with herbs and roots obtained from the healer;
2. The herbs and roots are mixed with water and sprinkled around the homestead;
3. All members of the family eat the herbs with food or dissolved in water to drink.

The ritual performance through sexual intercourse takes three forms including:

1. In the case where the deceased is male, sexual intercourse is performed between a widow(s) and the brother, or cousin or any selected relative of the deceased husband. In the case of a widower, this widower performs sexual intercourse with a sister, or a cousin or any selected relative of the deceased wife. A selected relative in both cases cannot be the elder of the family. Any elder is regarded as a parent and represent the ancestor, and because of elders status they cannot have sexual intercourse with their children;
2. A male member of the community is hired by the family to perform the ritual with the widow(s) of the deceased. The hired man is compensated for participating in the performance the ritual;

³⁶ *Xitonga* is cleansing medicine made out of herbs and roots, prepared by the healers.

3. Sexual intercourse between a married couple in the homestead of the deceased.

This couple could be any married relative involved in the burying process. A married couple related to the deceased substitutes the sexual performance between the widow(s) or the widower with a member of the family or a hired man.

The ritual 'sexual performance takes three days, three times a day. The couple is isolated from the rest of the family members in order to perform sexual intercourse. During these days the couple only goes outside of the house when they need to use a toilet. If the deceased had more than one wife, the man selected to perform *kupitakufa* has to have sex with each of these wives, three times a day for three days. In order to avoid a failure to perform sex to all the deceased's wives, the man takes *gonozororo*³⁷ medicine prior to the start of the ritual which must be performed without a failure. If for some reason the man fails to complete the obligation in one of the three days, the couple keeps it as a secret to avoid embarrassment and to avoid people know the failure of completing a ritual. Keeping the failure as a secret is to avoid people with supernatural witchcraft to take advantage and bringing *mbepho* and diseases and blame the abovementioned failure. A failure to perform sex during the ritual may annoy *mbepho*. During fieldwork, one key informant explained:

On the third day, the couple will walk out of the homestead of the deceased to go and cut their hair where the two paths meet. They will mix a portion of this hair with fluids from the woman's vagina and from man's semen together with herbs that were made available or accessed from the healers and use the mixture for bathing. All of the clothes that they wore during the course of the sexual ritual,

³⁷ *Gonozororo* is the medicine that gives a non-stopping stamina for sexual intercourse.

including blankets and mats are thrown away or washed with the above herbs. The house, including the backyard is also cleansed by a healer. The couple involved in the *kupitakufa* sexual performance is then allowed to use clean clothes. As a way of closing the ceremony, a plate with maize powder is placed by the doorway. This is a symbol of giving permission to people who participated in the burial ceremony to live their normal life, including having sex and other normal daily activities.

In Dondo and Maringue, abortion is considered as termination of life, not different from killing and is therefore regarded as death. Abortion like other death requires cleansing to a woman who has terminated her pregnancy. Abortion is regarded as very dangerous especially when it is done by an unmarried girl who lives with her parents. During fieldwork, girls were accused for provoking *phiringaniso* and bringing evil spirits to their families. One community member in Maringue argued:

...having a girl child in the family is risky, because girls tend to keep secret when they fall pregnant. Those who keep the pregnancy as a secret they normally plan to terminate. They terminate pregnancies without informing their parents due to the fear of embarrassing their parent. They know that no parent would be happy to know that their daughter is pregnant before marriage. This embarrasses parents because it is believed that the failure of a child reflect the failure of the parents in socialising that particular child according to their norms.

Furthermore, girls are aware that when they fall pregnant, all the freedom that they have is gone. They have to become responsible mothers and will never have chances to play again. Some girls are rejected by their boyfriends when they reveal

they are pregnant, and the only choice for them is to terminate the pregnancy. It is not easy to notice that a girl is pregnant at the early stage unless one is an expert. Old women are able to tell that a girl or woman is pregnant from as early as one to three months. You will hear a granny say that, that girl has changed her eating habits and physical appearance. But if parents fail to notice that their daughter is pregnant, their pregnant child has a strong chance to terminate a pregnancy. Some parent advices their children to terminate pregnancy because they do not want to be embarrassed in the community or they have better future plans for their daughters, like education. And where parents failed to notice that their daughter is pregnant, a girl can manage to keep it as a secret, but the family will suffer the consequences at a later stage, as *mbephos* are able to reveal the truth and the parents of this girl will suffer *phiringaniso*.³⁸

As pointed out above, abortion is regarded as death and as such the particular environment is believed to be polluted with evil spirits that requires cleansing. The same requirement of cleansing after abortion is the same reason why a widow or a widower should be cleansed. This means that all types of death including abortion require cleansing as discussed above and as the narrator on the risk pregnancy termination continues:

“...it is risky to allow a woman or a girl who terminated pregnancy to touch things around the house and cook for people, because she is not clean and everything she touches becomes unclean. It is worse when she cooks for her parents or members of

³⁸ *Phiringaniso* is a disease that occurs due to the failure of performing rituals where it is necessary. The symptoms of *phiringaniso* are similar to those of AIDS.

the family, because it is like members of her family are eating poison. The food is equally dirty due to her impurity. Parents or family members get *phiringaniso*. The only way to avoid *phiringaniso* in the family is to confess and get cleansed. If a girl or woman fails to confess, during the course of the *phiringaniso* sickness which may lead to the consultation with the healers, the healer will reveal the truth or diagnose the problem to the parents or any member of the family. The healer will use *tihlolo*³⁹ to reveal the truth and parents or family members will know everything about the termination of the pregnancy. A correct procedure should be taken, and the only way of reversing the status into a normal situation is to perform *kupitakufa* ritual.

Phiringaniso is a disease with symptoms similar to AIDS and this is the reason AIDS is locally conceptualised as *phiringaniso*. Symptoms that are associated with *phiringaniso* are weight loss, paleness in the face and skin, hair loss, cough with blood and diarrhoea. AIDS is in the context of biomedical associated with tuberculosis (TB) and this is similar to the cough with blood symptom in *phiringaniso*:

...In order to avoid *phiringaniso* a woman or girl who had terminated pregnancy must confess. This will prevent *phiringaniso* from the members of the family. In the case where a woman fails to confess and parents or members of the family know through the revelations from the healer, *kupitakufa* ritual is performed. The woman has to perform the ritual through sexual intercourse, while parents or members of the family take medication.

³⁹*Tihlolo* are bones that are used in telling what had taken place or what will take place.

The girl has to perform the ritual with the man who impregnated her and if he is not available to perform *kupitakufa* the parents or any member of the family should get a relative of this girl or hire another individual from the community. But in the case where a woman is married, that woman has to perform *kupitakufa* ritual through sexual intercourse with her husband. If the woman is not married, she must hire someone from the community.

Local people said that the process of hiring a person started in the olden times but had no payment implications. It was mentioned above that death polluted not only the family members, but also the whole community. Death is said to be a concern to everyone in the community and because of this understanding, people were willing to be part of the process because they know that during the mourning period, all the activities that people might perform are not pure and that the ritual performance is a transformation from liminal to post-liminal stage. This means that a hired man would perform *kupitakufa* willingly as his obligation as a member of the society. Traditionally, everyone in the community was obliged to accept the duty for *kupitakufa*. Today, due to the lack of social cohesion, people are hired for R250 to R1000 which makes the ritual expensive in the absence of family members or relatives to perform the ritual. For the unemployed men, this is an opportunity to make money. The payment is a new phenomenon and it has partly resulted from unemployment and poor economy and thus, the ritual performance becomes a survival strategy among the unemployed men.

Kupitakufa is performed within the intimate space but with permission from the parents or elders of the families and the society. The ritual makes a secret or private action

public, because the performance is initiated and authorised by the members of the family or elders of the community.

It was said above that death pollutes everyone in the community. The ritual in this case is perceived as having a role in cleansing every member of the community and sustains equilibrium in the society and secure solidarity among its members (Delfin 1991:3). Gluckman (1954; 1958) and Turner (1957) argue that “rituals are a mechanism to secure and to ensure societal unity”. Death breaks the relationship between the dead and the living members of the family; it is in this context *kupitakufa* brings unity among the members of the family and the community, and spiritually connect the dead and the ancestors with living people.

A community meal is made available after the burial of the deceased and after *kupitakufa* (Martinez 1989). Both meals have the same meaning. People who went to the graveyard for burial have to wash their hands from the same basin. This water is prepared by the members of the family. The water contains medicine believed to have power of chasing bad spirits that might have followed people from the graveyard and this water has thus mystical meaning. The community meal is offered by the relatives of the deceased as a sign of spiritual union and appreciation to all the support that members of the community have offered to the family of the deceased. According to Martinez (1989: 215) the community meal has the meaning of intimate unity between the members of the family and the community with the deceased including the ancestors. However, it also means social unity among community members. People continue to keep the family company for a number of days.

During the mourning period people symbolically accompany the deceased to his/her trip to the world of ancestors (Martinez 1989: 219). The ritual is strongly believed to be a supernatural connection between the dead and the living. *Kupitakufa* is interpreted by the community as a cultural practice that is still powerful, and believed to have the supernatural power, with the interpretation of death as a moment of universal solidarity and the acceptance of death as obliged passage for all people. They believe that the spirits of the ancestors do not only come during the ritual, but are always present among people and protect them from bad spirits.

These cultural performances are blamed for encouraging risky behaviours that, for example, spread sexually transmitted infections, including *xirombo*/HIV and *phiringaniso*/AIDS. If people fail to perform the rituals, *mbephos* will punish them, and if they perform, they run the risk getting disease. This is a dilemma that place people in a complex situation as it is not easy for the people to reject traditions out of respect to their ancestors and with the love of their culture. Nonetheless, because cultural practices are associated with the spread HIV, people are divided in their opinion about traditional cultural practice. Some people have decided to stop the ritual performance, especially people who have converted into Christianity. These people argue that cultural practices should be forbidden. Among the opponents of traditional cultural practices, there is however those who fail to practice what they preach. One of informant argued during an interview that:

“Some Christians are not Christians but church goers. They perform these rituals undercover because they do not want other Christians to look down on them. The lifestyle of Christians is to share responsibilities. They therefore advise and look

after each other on daily basis. It would be easy for another member of the church to know that their members performed rituals contrary to their belief system. As a result, families that are dominated by Christian religion perform rituals undercover. They practice the ritual during the night and behave as if they hate the practices. The reason for practicing these rituals undercover is due to the fear of other members of their churches, and the fear of ancestors' spirits, which reflects a strong belief in cultural values.

Kuphitamabzwade Ritual

Kuphitamabzwade is a ritual performed in relation to childbirth. This ritual takes two forms as follows:

1. the postpartum period before the parents resume sexual intercourse is between 60 days or 6 months depending on the decision of the head of the family who oversee all the cultural practices in the family;
2. the process of burying the unborn or the child that died under the age of 60 days, including the period that is spent before the mother of the dead child can have sexual intercourse with her husband.

During the period of *kuphitamabzwade* the husband and wife are separated and not allowed to have sex. The mother and the new born baby are isolated (Martinez 1989; Deflem 1991; Turner 1957) from the rest of family members. The purpose of isolating the mother and the new born baby is to allow the baby to adapt to the new environment as a new born baby. It is believed risky to expose a new born, because some people

might give the child evil spirits. During the *kuphitamabzwade* period, members of the household are not allowed to touch the belongings of the mother and the new born child, only old women, especially those who are no longer sexually active, or those who have reached menopause, are allowed to assist the mother and the new born baby.

It is believed that if the husband and the wife touch each or perform sexual intercourse other during this period they invite disease. A woman will suffer from “*swollen feet*” and the man will suffer from “*swollen testicles*” and the baby will get diarrhoea. However, the isolation of both mother and child can be interpreted as protecting a child from the people who might be sick and to allow the mother to have enough time to rest and to breast-feed her baby. In this context, *kupitamabzwade* can also be understood as a process of family planning as one of my key informants said:

It is a traditional way of family planning. This is planned from the olden days as a way of controlling birth and preventing couples from having sexual intercourse during prohibited times for a period of 2 years. There was no family planning injection and tablet in olden times. People fell at risk of falling pregnant while a new born baby has not been given enough chance to grow or breastfed. It is risky for a child to be breastfed by the mother who is pregnant. *Kupitamabzwade* is thus believed to give a chance to a child to have clean milk from the mother. Men can have sexual intercourse with other women, but not with the mother of a new born baby, especially if a man is married to more than one wife. On the day that the couple are allowed to have sexual intercourse, the baby must be given herbs from a healer to prevent the child from getting sick. As in the *kupitakufa*, the couple have to bath and throw away the clothes and the belongings that they have been using

during the period of the ritual. The couple mainly the woman is reintegrated to the normal life within the community.

Besides childbirth, *kupitamabzwade* is also performed when miscarriage occurs or a child dies before 60 days. The reason for giving a period of 60 days is to allow time to heal both the body of a woman and the hearts of the couple. The death of the unborn and the child under the age of 60 days is culturally regarded as the responsibility of the mother because the safety of the unborn depends on the health of the mother and the same applies to the child under the age of 60 days who is at this time only under the care of the mother. At this age, the child does not exist to the other members of the family and this is made sense through the isolation of the mother and the child to the members of the family (Martinez, 1986). The mother is, therefore, responsible for burial process of this child under the supervision of elderly women. Only women are allowed in the burial process of the child. The father of the child should not be informed before the child is buried. Furthermore, the mother of the dead child should be naked during the burial process, and this is another reason men are not allowed to be part of the burial process. The grave is dug by women and should be shallow. It is symbolically believed that if the grave is too deep, the mother's womb will close and she might not fall pregnant any more or take time to fall pregnant as one of the informants explained:

...we cannot dig the grave deep, because the mother has to substitute the child in time. The woman's womb is a space that is prepared for one reason that is to carry the baby for a certain period of time. The dead child or foetus symbolises the womb

of the mother and she is responsible for digging the grave before everyone. Women will then assist or take over and dig enough space to cover the baby.

This is followed by the process of laying down the cloth that the mother of the child used to hold the postpartum blood and place it in the grave in perpendicular form. The mother, during this process has to be undressed. Just before they leave, she will pull out the cloth slowly until it comes out of the grave and this ritual of pulling out the cloth implies that the dead baby would soon be replaced. The cloth should be kept under the bed. It is expected that the woman get pregnant after three months of burying the child.

After the period of *matsi yaku phisa*, meaning the period of massaging the body using hot water to stimulate blood circulation, that takes place after the birth or the burial of the dead child; the couple must resume sexual intercourse. The first sexual intercourse must take place on the cloth that was pulled from the grave. , Elderly women wet the cloth with a mixture of herbs and wring that water for the mother to drink. After that, the cloth must be burnt and the mother has to lick the ash. A day after the couple performed *kupitamabzwade* sexual ritual, the mixed fluids from sexual intercourse are collected and mixed with medication and water for bath. The couple has to take bath, and this is a sign that they are ready to make another baby.

Kupitamabzwade takes different process depending on the life or death status of the baby. Compared to *kupitakufa*, there are different actions in *mabzwade* performed to protect the baby or to give permission for sex to resume or for baby or foetus burial. *Kupitamabzwade* is also called the ritual for allowing a husband to have sex with other

wives especially in the case of polygamous marriage. During the time of sexual abstinence with the mother of the living or dead baby, the husband can have sexual intercourse with other women, but he must be authorised by the mother of the baby who is at this time have the authority give her husband a permission to have sexual intercourse with other women and the husband has to respect the wishes of mother of the dead or the living child under the *kupitamabzwade* process, as one of the informants explained:

If the husband has extra-marital relations he has to be careful during this period, because the mother under the *mabzwade* period must not know that the husband is sexually active during the period that they are both not allowed to have sex. At the day of resuming sexual intercourse the his wife, she expects her husband to confess. If he does not confess and touches the living baby, he is believed to be burning the baby's body or making it impure. The baby will then get sick if medication from the healer is not made available; the child will have difficulties in growing and this is reflected by the increasing size of the stomach of the child. In the case where the medication is made available, the father of the child must confess during his first appearance before the healer and without this confession the medication will not be effective.

For the process of healing, the couple is expected to go where two paths cross each other, accompanied by a healer. At the crossing path, they had to prepare grain meal with chicken and eat, and father of the child will say the following words: "*cubiwa mabzwade*" which means I did not care for the baby meaning that "I betrayed the health of the baby by having extra-marital sex". After saying these words, they have to

go back home and give the child medication from the healer. This medication is taken for three to four days.

As mentioned, the process of confessing is a way of controlling the man's behaviour. The confession can end in a separation or divorce, especially if the wife fails to accept that her husband has had been engaged in sexual relations during the time the two were not allowed to have sexual intercourse. The situation in this regards does not only apply to men, but also to women. If it is found that the wife was engaged in sexual intercourse during this period, fights between the husband and the wife can lead to a divorce. During the olden times the period of *kupitamabzwade* took about one to two years but it shorter today.

Not everyone values these ritual performs these days and these are people who view these rituals as meaningless cultural practices. Young people are the culprits in dishonouring ancestors and cultural practices and cheating tradition. A young man of 22 and a secondary school student narrated a story about him and his wife when they decided to cheat requirements of ritual performance and said that,

We young people do not value our culture equal to our parents. This is due to the fact that young people question everything; they want to know the reason behind every action taken. They use education to interpret the meaning of life. Some of the action taken according to our culture does not require education, but are meaningful to those who respect their culture. Many of the actions taken are taboos; they do not have a direct explanation but an understanding that comes through spiritual gift.

Our ancestors were clever that all the actions that they approved as guiding

principles have significant meanings. My wife miscarried and we cheated *kupitamabzwade* ritual. What I did was to give my wife a time to recover and we waited for a month without having sex. We did not tell any one about our situation, it was a secret between me and my wife. If one decides to cheat the ritual, one just have to keep it a secret, otherwise people will take an advantage and send you *mbephos*. I asked a healer to give us herbs and we cleansed ourselves using this medicine. The only part that we cheated towards the *kupitamabzwade* was a waiting period. We could not endure until the required time. We needed each other so much. It is important that couple be at the same place when experiencing problems in order to ease each other. Even though we cheated the ritual, the belief on the power of the ritual does not go away. One keep reminded that he/she has cheated the ritual, especially when one experiences difficulties. One tends to have a feeling of that bad things are happening, because of cheating the culture. Ancestors are always watching us.

Kupitamoto Ritual

Kupitamoto ritual is performed when a house is burnt by fire. If a house burns, people interpret the situation as caused by *mbepho*. *Kupitamoto* is the ritual of purifying the environment of the homestead from the evil spirit (*mbepho*) that may have caused the house to burn. In order to perform the ritual the family consults with a healer, specifically, *n'ganga* who guides on procedures and process to be taken, including prophecies on the origin of the *mbepho* that cause the house to burn. As in the *kupitakufa* and *kupitamabzwade*, the process of *kupitamoto* also involves sexual

intercourse. The couple, specifically the owners of the house must perform sexual intercourse ritual. If the owner of the house is single or divorced, he or she should look for someone to have sex with. The ritual should take place before the rebuilding of the house and this sexual intercourse should be performed at the same place where the burnt house was situated. *Kupitamoto* can be understood as a process of negotiating with the spirit that has caused the house to burn.

The main reason for performing rituals, as is, clearly evident from the description above, is to prevent *mbephos* by negotiating with the spirits of the ancestors to prevent the problem to reoccur. They appease any misunderstanding that can result in the harming of people. Furthermore, all the rituals performed among these people are socially constructed according to the cultural norms and each ritual relates to one another.

Rituals are the processes of connecting living people with the dead/ancestors or a communication between them. As the composers of the practices, the dead sustain the practice through the performance that is taken by their descendents. This means that if an individual fails to respect cultural practices, that particular person has cheated his/her ancestors, and the ancestors may bring *mbephos* as to punish the offender to sustain the practices. There is no scientific explanation in these practices, but each practice makes sense among the people who use them. The practices are guiding principles in the lives of the people, and make the lives of the people meaningful. But the meaning would not make sense if it is approached from the western point of view and this is the reason for this thesis calls for a local method in interpreting the meaning of cultural practices in health practices.

It is interesting how local people describe diseases such as HIV/AIDS as *xirombo* and *phiringaniso*. These people understand HIV, for example, as *xirombo* and are able to interpret it in the same way as the biomedicine interprets it. In HIV/AIDS, the concern is multiple sexual relations that are viewed as a tool of transmitting the disease. In *phiringaniso*, people are able to understand that sex transmits diseases and because of this reason, they employ other ways of performing the rituals, for example, not allowing a widow or widower to have sexual intercourse when there is suspicion that the deceased may have died from an infectious disease. People understand these diseases from their perspectives but can be misled when other methods of interpreting these diseases are used. Because of the complexity of this situation, the newly introduced ways of explaining experiences to these people becomes incompatible.

The issue of conflicting cultures seems to be empirically proven in the HIV/AIDS prevention intervention strategies. People in Dondo and Maringue acknowledge the western approach in HIV/AIDS, but continue with their practices. This shows the power of indigenous knowledge and inherent practices in interpreting the meaning of each experience. But the lack of understanding from the public health that is based on the western perspective fail to see that indigenous knowledge can play a significant role in reducing the spread of HIV/AIDS. The western approach is of a view that people should change their culture in order to survive. This approach view cultural practices as a tool of spreading the disease. There is the failure to see that it is not cultural practices that are risky, but the method of performing these cultural practices. Any sexual relationship has in it a risk of transmitting disease, but this depends on the manner in which the relation is performed. HIV/AIDS prevention interventions lack

interactive dialogue between providers and recipients of the information in Mozambique. Cultural practices described above should be used as tool of preventing the spread of disease through an integrated approach that would recognise the local cultural practices as part of a new strategy against the spread of HIV/AIDS.

Meaning of Rituals in the Context of HIV and AIDS

A focus on rituals arose from the group discussions between teachers, activists, community members, and people living with HIV/AIDS. The very same questions were asked and debated during the focus group discussions with teachers and the members of one of the homecare-based organizations. A concern on the impact of ritual on HIV and AIDS was raised. People argued that rituals are risky, because they are tools in transmitting HIV, although they also expressed the view that condoms transmit diseases. This response indicates that people are confused from contradictory information they receive from different spheres of the society. The situation is confusing because even people who have knowledge about HIV prevention also support and believe in the power and importance of ritual practices, which is against condom use. However, other people have suggested that ritual practices should be declared unlawful particularly those involving sexual intercourse and must be banned and that changes in the belief system might be positive in resolving this difficult situation. Alternatively, people can turn against their cultural belief system and follow other religions outside their culture as one of the community leader argued that:

Christianity cannot be a choice in replacing these cultural practices, because the bible is full of stories on rites of passage and has therefore no strong basis to defend

against ritual practice. In order to stop people from performing rituals, it is necessary to transform people from traditional belief system to Christianity. Christians do not practice these kinds of rituals and nothing wrong happens if one fails to perform these rituals. People who perform these rituals are those who do not attend churches. Nevertheless churches will not have a power to stop traditional practices if traditional practices are viewed as norms that educate people. People perform the rituals because of the fear of spirits that are said to possess people and cause death and diseases in the families. (June, 2007)

According to some of my informants in Dondo and Maringue, it is necessary that people transform from their culture to other cultures, and Christianity was suggested as the tool that can transform people into ‘acceptable’ cultures. But Christians who go against Christian behaviour also fall into risks of HIV/AIDS infection. However they argued that the situation between local cultural practices and Christianity is complex because cultural ritual performances do not contradict with the bible since the bible also teaches about the rituals and their meanings.

The rituals have the power to influence the lives of the people and this is determined by the meaning of the ritual in their daily lives, and as a result, people continue to find rituals to be a part of their culture, the culture that in return play a role of creating an identity. It was made clear above that people fear what would happen when they fail to perform rituals. Turner (1968: 14–5) states that “a belief in the existence of a high God who has created the world, does not interfere with worldly human activities, in the existence of ancestors and spirits or shades who may afflict people; a belief in the intrinsic efficacy of certain animal and vegetable substances; and belief in a destructive

power of female witches and male sorcerers”. For example, a failure to perform a ritual that cleanses death means that death is still among the people. Rituals such as *kupitakufa*, *kupitamadz Wade*, etc are the responsibilities of each member of the society, and become the social field or action field (Turner 1968: 87-88 in Deflem 1991).

Rituals engage different structures of the community in a dialogue reviewing the meaning of life and how each action should be taken. Ritual relates to the lives of the people and how an individual person is related to the other. For example, the family of the deceased is responsible for organising the ritual, but the ceremony involves everyone in the community, including healers. The process brings everyone together, reminding people who they are in terms of their culture and healing, calming and negotiating. This means that rituals allow a dialogue among those who are still alive and those who are dead.

It became evident that the performance of the ritual is influenced by the belief of the people. Some people believe nothing will happen if a person fails to perform the ritual or a ritual can be meaningless as one community leader narrated in relation to *kupitamabzwade*: “....nothing will happen if you do not perform required rituals, but in the context of tradition one must confess to avoid bringing more diseases in the family”. (October. 2008)

The above statement was noted during a group discussion concerning disclosure of information when, an individual for some reason, (the father of the child) transgressed the *mabzwade* burial process. Although people have doubts regarding the consequences of failing to perform the necessary rituals, they still have a strong belief that spirits are

watching their behaviour, and will be punished if they fail to oblige. The belief is used to discourage men from transgression of cultural norms, because the rituals simultaneously expresses and creates the sentiment of dependence on a type of moral or spiritual power that is thought to transcend the realm of the human (Bell 1997:59). Apart from this ceremony it is expected that the woman would get pregnant as soon as possible. However given such a woman is still not healthy to carry a new pregnancy, it can mean she is vulnerable to sexually transmitted infection including HIV, as Pedro one of my key informants said:

My wife's first pregnancy was miscarried and we spent 2 months, without having sex. I was no longer staying in the same homestead with my parents, but I informed them about the development around my life but for this I did not tell anyone around my homestead; and we never experienced any problem. What I did was to give time to my wife for two months to heal, and after that we resumed having sex and nothing happened. My father came to check if we performed *mabzwade* and I lied to him and said that we asked one old person for an advice, but I was lying. So I did that because I had a confidence that nothing will happen in the case of failing to perform *kupitamabzwade* or *kupitakufa*. One has to consult with the healer and access medication for cleansing and do it yourself.

Pedro was a student at a secondary school and he was also a coordinator of local theatre for civic education in the community. His role was to advice people on early consequences of marriage—guiding people to avoid early marriage and also informing people about the importance for pregnant women to attend antenatal clinic as he stated:

....our people are influenced by the rumours that hospital kills people, that the injections administered in healthcare are giving illness to the people. So we go to the community to explain the importance and advantage of pregnant women attending the hospital, the need of taking the child to be taken to a clinic when he/she was sick, we had to explain to them the dangerous signs.

Pedro was well-informed about the culture and cultural practices of the local people having been born in Maringue. He was of the opinion that to avoid a clash with elders, one needs to maintain privacy, because it is disrespectful to the elders to know that someone failed to respect cultural practices where necessary.

Apart from confrontation with parents, the youth, as in the case of Pedro, uses silence to introduce changes in their cultural practices. They bridge the gaps in the process or procedures to be followed in ritual performance. In other words they perform what they think or feel it is necessary and omits what they feel is unnecessary. But they normally omit the difficult part of the ritual. For example, if a ritual has to take a longer period the ritual performer shorten the period and omit other necessary steps. Pedro is one of the people who think and believe that HIV/AIDS prevention interventions can be done within a local cultural background. Most people supported the idea that ritual is a way of preserving culture. Although Pedro was aware of the fact that anything can happen to an individual who fails to perform the required ritual that involves having sex without a condom, he suggested that HIV and AIDS programmes have to be done from the cultural point of view as he argued:

.... another issue in preserving the culture is that not everything our elders say is wrong. For example, in the case of death, the members of the community must change the way they conduct themselves. Sex is something that is believed to be 'hot' during mourning period. If you go and jump around with girls and perform sexual intercourse, you will suffer the consequences. Your body will be as hot as the 'hot' sex that you performed. Wait until the cleansing processes are done, otherwise, you will be bringing a 'hot body' back home. As young people we cannot stop our parents from performing necessary rituals, there are necessary things that we need to follow.

This intervention is a perception of someone educated who could voice the situation around ritual performance, especially sexually related rituals such as *kupitakufa*. Other than the belief of the power of the spirit, *mabzwade* is crucial for regulating behaviour of people involved. The ritual assists in regulating how people should conduct themselves during sensitive times like birth, death and so on. Furthermore these rituals, whether positive or negative they have a social value because they support and maintain cohesion. Gluckman (1954; 1958) and (Bell (1997) stated that rituals are a mechanism to secure and insure unity in the society, although this unity can be achieved in the environment that is free from social conflicts and competing norms and values. The current health approach, especially on the issue of HIV/AIDS prevention that differ from that of the local cultural interpretations of diseases, including HIV/AIDS and this has created a conflicting environment, that pushes people to speculate on what is right and what is wrong, as one member said in a focus group discussion that:

....not every thing that the elders say especially in the case of death and their rituals are nonsensical. If a relative dies, despite of us being accused of disrespecting our culture due to education, young people tend to break rules and have sex before performing required rituals and as a result we get cursed by the annoyed spirits that bring sickness and bad luck. It is not possible that we advice the elders that *kupitakufa* be eliminated in our culture the reason being it allows or is risky in terms of HIV spread. (October, 2008)

There are educated people who still keep to their traditional cultural practices as is clear from the quote above. This an example that people use education to assess their own culture, and therefore, take what they feel is necessary to perform and leave out what they think is unnecessary, although the assessment of culture, is also the fear of the supernatural spirits which is representing by ancestors. What is interesting is that people are able to interpret the meaning of HIV/AIDS prevention in both western biomedical ideology and in local cultural belief system and choose which approach they should be used. Both western ideology and African ideology interpret HIV/AIDS differently, but local people are able to understand and contextualise HIV/AIDS in these two different ideologies.

In assessing the attitude around the impact of ritual on the spread of HIV/AIDS, some people suggested that it would be necessary to stop people from practicing these rituals. But they further argue that this would not happen overnight. It will take long for people to change and adopt practices that would be safe. The reason they feel it will take long time is that for people to change from one culture to another or transform their own culture, they have to convince people why they should change. This clearly

shows that the reformation of culture takes a form of processes, and is well evident in the following quote from one teacher during a focus group discussion:

...I feel we did not discuss enough about our rituals, what I want to demonstrate is that the performance of these rituals went hand-in-hand with time, the environment and with certain generation. I am convinced that the practice of these rituals, e.g. *kupitakufa* did not have bad and risky consequences at that time, because AIDS did not exist during those times. In this new generation, people have changed. Their faith and beliefs are not that strong when compared with that of the old generations. The environment too has changed—there are a number of sexually related diseases that are risky. Despite this dilemma of performing or rejecting rituals, we need to give enough time to our elders, especially our traditional healers to understand why we need change, so that they make informed decisions on these rituals. (October 2008)

From this discussion, it is clear that local people suggest the needs of transformation with regard to performance of rituals as a strategy towards change. But their argument does not say people should reject ritual practices. Obviously, if the disease did not exist, the ritual practices are accordingly not problematic. Nevertheless, this suggested that transformation should be started by changing people's attitude that would come through allowing people to learn about the situation in order to understand and make informed decisions, as one member of the group discussion argued:

The world is changing, its transformation is now in a more advanced stage than before, and we need to change with it. We are experiencing many diseases. People

are dying in large numbers due to these diseases. If I get involved in performing *kupitakufa*, it means I am looking for or inviting disease. One cannot perform *kupitakufa* with a condom, meaning that I am running risk of getting HIV, which I will transmit to my wife (wives). We need to find a way to educate our elders, surely they will understand since the situation is logical. Mythically, the rituals prevent sickness, by pleasing the annoyed spirits, but they help us to transmit HIV.

This is really a dilemma, especially because ritual performance is an obligation, but also risky if one fails to please the spirits of the ancestors, but the manner in which ritual performance are carried out also bring serious and dangerous situations, particular on the sexual performance that exposes people to HIV/AIDS. The situation requires some serious thinking as all sexually active persons are at the risk of getting HIV/AIDS. People have not stopped to engage in risky sexual relationship, although they may know that such sexual relationship exposes them to HIV/AIDS. They claim to deal with the situation with measures that can prevent them from getting AIDS, but these measures do not guarantee protection. The same applies to ritual performances which continue despite people being well-informed about the risks.

The situation is much more complex than one can estimate. Change is something difficult to achieve especially because it is hard to make everyone understand the reasons for change. People are influenced by different perceptions and one's perception can not determine how other people think. It is not only 'rationality' that can explain the reason behind every action. Both tested and untested information equally influence the manner in which people make decisions and conduct themselves. It was argued

during the group discussion that: "...it is not easy to stop practicing what is in one's heart; it is easy to throw away what is in one's hands".

This is a powerful statement suggesting that people do not shift to imposed change. People live their lives in their socio-cultural environment using these ritual practices, as the perspective from which they adopt change. This is one of the reasons some people were of the opinion that it is hard to get people to change their belief in rituals. The practice can be prohibited legally, but people would secretly practice what is in their hearts. It is, however, important to note that if rituals are a vehicle for construction of relationship of authority and submission (Bell 1997: 82), their absence or violation will have negative impact on the relationship among people and between people. The relationship between the elders as people who facilitate the transfer of knowledge on rituals to the young generation can change negatively if the situation gets imposed rather than being negotiated.

This thesis argues that parents feel no power over their children. The situation is chaotic because children take whatever they get from wherever without consulting their parents and conclude that they are knowledgeable. This makes children turn against their parents; and parents are not able to advise them. As a result, children fall into traps as they make wrong decisions in their lives. The reason for viewing culture as something that take time to change also refer to the issue of "for the love of my culture" because people question almost every new thing in their societies that try to take over their current practices. Even if the new thing makes sense, people still resist change, because they need to know what the new brings to their lives. It was presented above that: "there are still a large number of people who do not consult with hospitals

and clinics, but use healers for almost all of their health needs including childbirth. It is obvious that people neither test themselves for HIV and AIDS. According to one care giver:

....we work with community on civic education involving both women and men even though there are some issues that concern women more than men. It is important to involve men on women's issues so that they will be both being at par in terms of understanding new concepts. Currently some people are against hospitals or biomedicine, there is a myth that western biomedicine are here to spread diseases to the people. But working with communities will help them to understand and see the benefits of using hospitals, and they will as a result adopt western or biomedical practices

Culture changes slowly in Dondo and Maringue. A better way to collaborate with all stakeholders in the community, as one community AIDS activist argued will be crucial:

My suggestion is to work together. There is a need for working with every member of the society including healers, religious groups, etc, in order to establish and assess the possibility of adopting cleansing rituals without sexual intercourse or applying prevention devices if they have sexual intercourse. This can be achieved through assisting people to see that we are in danger. People have to understand the danger behind these practices, but telling people to stop performing these rituals is not an option. The most important thing is to continue with the performance of our

cultural practices with precautions of avoiding risk of HIV and AIDS”. (October 2008)

Barnes (2003:214) argues that the teaching from elders is shared within a relationship that encompasses both an intellectual and emotional quality. Thus the intension of oral transmission is to maintain a relationship rather than the transmission of tradition. There is fear of failing to influence young people to follow the traditional beliefs. They use metaphors as a strategy to maintain the traditions. The use of metaphoric words helps avoid direct explanation to young people, but this makes it difficult for children to ask their parents or adults on issues related to sex and sexuality. The children are simply expected to follow the instructions without understanding the meaning behind such instructions. Nevertheless the silence on sex and sexuality has impact on HIV infection. Although some children have the ‘opportunity’ to interrogate elders when they have concerns on certain issues, asking an elder for an explanation is regarded as lack of respect.

The silence occurs because *kulangiwa* as a medium of instructions and a field of providing knowledge to children is no longer a usual practice. There is little communication between parents and children on matters of sexuality. This silence affects their knowledge on social life including behaviour around sex, sexuality and HIV/AIDS prevention. Moreover, children are exposed to different and sometimes contradictory discourses resulting in confusion among them. Rites of passage were used as tools for transferring knowledge from adults to children about to enter the adult stage. With rites of passage being no longer in practice, children are on their own. Communities have lost the space for teaching their children about necessary issues.

The only way currently available is to find a way to relate and integrate different social institutions such as hospital, the African healing practices, schools and the NGOs who act in the health sector to intervene in order to avoid risky behaviour, as one of the community leaders said that,

...hiring an outsider to assist in performing the ritual is perhaps necessary, because some diseases are hereditary and with the use of an outsider, avoidance of transmitting or getting the disease, as happens with some respiratory diseases can be made possible.

Hiring an outsider to perform the ritual although is not a solution, because that particular hired person might also been suffering from or affect with diseases. Beside people use this as a means of making money. These kinds of people are less conscious about the disease; if they care, they would not agree to these risky practices. Thus they place themselves and other people at risk of HIV infection. But again the practice is a challenge to the government in terms of economic and social or health development, where people place themselves in risks for economic gain. This is a serious challenge, because it also compromises the government HIV/AIDS prevention interventions.

There is a 'rumour' that if a female partner is infected with HIV, a male sexual organ automatically sense that there is a problem and during the initiation stage of sexual intercourse, the male sexual organ becomes inactive or dysfunctional. According to this belief sexual intercourse will not take place. People place themselves into the risk of HIV/AIDS even if they are aware of the risks and as some are able to recognise some

external symptoms of AIDS. This is one of the messages that confuses people with regards to HIV/AIDS.

It is a strong belief among the people of Dondo and Maringue that if a sibling dies, it is the duty of the living sibling to protect the family and the community around. But in the case, where the family has to hire a person to sleep with the widower or the mother of the dead or aborted child, the situation places both at risk, more especially if one of these people is suffering from diseases. Maringue, as I said is one of the districts where until December 2008 the number of health prevention interventions actors was few.

Rituals and the Symbolic Recovering of the Social Order

The different meanings, perceptions and roles of *kupitakufa*, *kupitamabzwade* and *kupitamoto* rituals need to be analysed together. While *kupitakufa* is about death cleansing of the family of the deceased and the community, *kupitamoto* is also cleansing of house/home from the *mbephos* that burns down the house mysteriously.. *Kupitakufa* cleansing is between people and their dead relatives or ancestors while *kupitamoto* is cleansing between the people and the space or the living space. Both rituals have roles since death and burnt house are interpreted as signs of instability of an individual person's life/behaviour including that of the family and the community. Because of this reason, everyone sharing daily life with the family of the deceased is said be polluted by the "*mbepho*" or spirits of the ancestors may be responsible of the death. *Kupitakufa* and *kupitamoto* ritual are performed to reduce, exclude or resolve conflicting situations (Turner 1957: 89). Performance implies activities and actions translated into sexual intercourse preformed according to the required processes and

procedures. The reason for following the correct processes and procedures is that , for example, in the case of *kupitakufa*, sexual intercourse is a function of healing that take place through the mixing of fluids, and thus the roles go beyond the mechanism of redress not only through sexual intercourse but also through sacrifice (Ayikukwei et al. 2007) in order to cure *phiringaniso*. In order to cure the disease the relatives call the *nyamusolo*, the spirits to smell the *mbepho* or other kind of spirits or *mungoma* who normally use dice for divination, and believed to have powers to identify the causes of disease. According to Chidester, healers are “experts in discerning the cause of any misfortune whether the cause is attributed to the work of a person or the wrath of ancestors’ (1992:18).

A disease is seen as experience that happen to anyone and it is understood as breakdown of the individual’s normal life, stage where the individual stays in the luminal and marginal state (Martinez, 1989:180). For this reason an individual or the people around will do everything to restore the normal order. This is one of the reasons the healers are viewed as important.

Figure 10 represents or summarises the processes and procedures taken in cleansing for both life/death and for burnt house. Sexual intercourse is central in the performance of these rites.

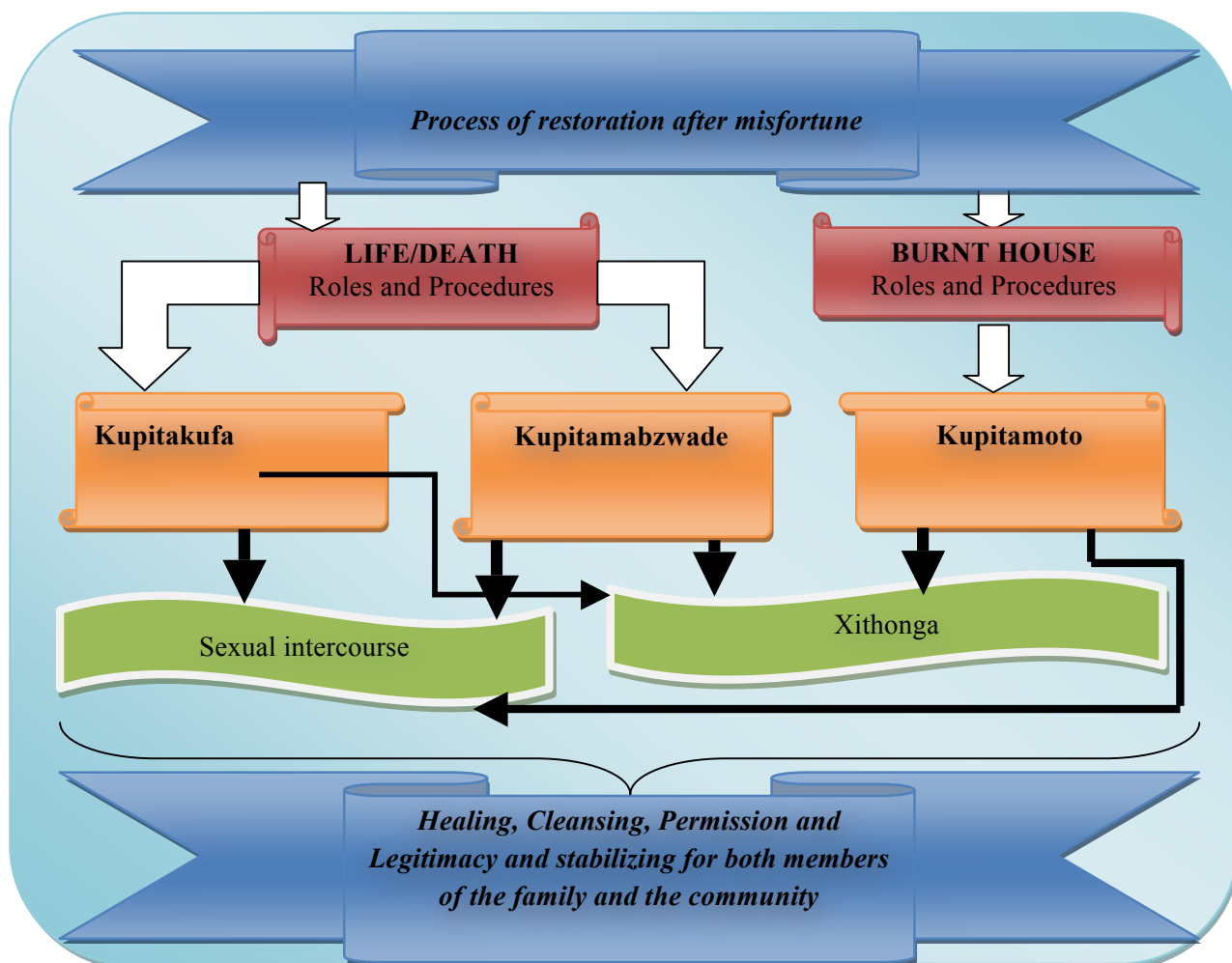


Figure 10: Rituals Processes and Procedures

Kupitakufa is a ritual of cleansing, legitimating the changing from one state to another. An individual is placed in a liminal state as though he or she does no exist any more in the household or in the society. Ritual performance restores or places a person in a certain position which gives the person an opportunity to rebuild the living situation as an individual and as a member of community. Thus choices made in hiring a member of the community who makes himself available for the sexual intercourse service, or asking a married couple to perform the ritual, or use *xitonga* play a role in the

transmission or prevention of HIV and AIDS. However the government AIDS campaign programmes still marginalise these practices, with the view that cultural practices are backward thinking. The government fails to recognise that people believe and use rituals as tools for restoring social balance that is broken by diseases and can at the same time used to develop people.

The performance around *kupitamoto* ritual gives results similar to those of *kupitakufa* in terms of exposing to HIV infection since they involve sexual intercourse. If the owner of the burnt house is single, an outsider should be hired to performance the sexual ritual. The only differences is that a married couple, for example, the owner of the house perform the ritual, which does not therefore expose them to disease entailed when the ritual is performed by an outsider. But if the owner is single or divorced he/she run risk of hiring an outsider. The ritual performance must be performed in the burnt house and the procedure is believed to assist the healer identify the culprit. The guilty can be a living person or an evil spirit sent by a living person or the ancestors.

Kupitamabzwade ritual is as discussed earlier is a ritual that plays a role in family planning since the practices are used to guarantee breast-feeding until the baby is independent to feed himself/herself. Like in *kupitakufa* and *kupitamoto*, *kupitamabzwade* ritual also has impact on HIV as was demonstrated in the healing of *phiringaniso*. The ritual as discussed earlier has “a lot of power on the family in enforcing all prevention and curative health aspects” (Ntseane 2004:13). Participants in this study described how in the past this function was done successfully under the supervision of the family members in different ethnic groups because of its association with initiation rituals (Ntseane 2004). With the emergence of HIV and AIDS “the

family's involvement was overlooked". Because of the local realities including limited access to information and health services, people still use cultural practices for curative and prevention of disease.

Local Perception on HIV/AIDS and Diseases

In Dondo and Maringue people consider both the formal and the informal HIV/AIDS prevention intervention strategies and the situation self manifests the ritual performance that includes sexual intercourse. Local cultural practices in health prevention that includes HIV/AIDS are reinforced also by local notion or conceptions of the pandemic. In Maringue and Dondo people's definition of HIV does not differ much from that of the scientific. Some people believe in the biomedical notion of the disease, of which the biomedical notion is derived from the HIV/AIDS prevention interventions that defines HIV as Human Immunodeficiency Virus (Paton 1999:390). The local definition of HIV is defined as a small or tiny but a dangerous disease that carries death in it, and named "*xirombo*". AIDS is locally defined as "*phiringaniso*"—disease with symptoms similar to AIDS, for example tuberculoses (TB). Tuberculosis-like symptoms followed by diarrhoea, lack of appetite and weight loss, hair loss and paleness are associated with *phiringaniso*.

Currently, because of fear of infection with HIV, communities have come up with local cultural practices which are used as a strategy to avoid the sexual contact among those expected to perform rituals. Nevertheless the final result for these rituals is to prevent people or community from death, pollution and diseases including HIV and AIDS. However the manner in which the practice is carried out increase chances of spreading

HIV/AIDS. This is one of concerns the school youth expressed and viewed their ritual performance involving sexual intercourse as risky behaviour. One student asked: “Is there a relation between AIDS and traditional diseases? In other words does AIDS means *kupitakufa*, *Mbepo* and *Mabzwade*?” (A 19-year-old boy).

Although this questions reveals some misunderstanding on the meaning of the three concepts, young people have noticed how the concepts are interrelated, that their existence and meaning revolves around evil spirit possession, cleansing, and post-partum period. AIDS is a disease acquired through sexual intercourse and *kupitakufa* is a ritual involving sexual intercourse without condom use, to allow mixing of fluids from man and woman. This mixing develops a healing power; for healing the partner and at the same time restoring a healthy environment for the members of the family and the community. But in the process of cleansing (*kupitakufa*) people run the risk of getting infected as indicated by another student in the question, “Do the traditional ceremonies like *kupitakufa* be a problem to AIDS?” (A 20-year-old boy)

The relation of *kupitakufa* to AIDS in the questions above, shows there is knowledge that the meaning of cleansing is through sexual intercourse and therefore that performance with a condom is meaningless as reflected in the following conversation:

Member: Hmm! In doing so (sexual practice without *jeito*) does the disease disappear during the process?

Facilitator: Yes, what do you think?

Member: I do not understand how, but if you use *jeito* you are not performing sexual intercourse but joking.

Facilitator: why is that a joke, see, you advise people to use *jeito* but you do not practice what you preach, how would you encourage children?

Member: It is complicated. When I go to my bed some words vibrate in my ears. I ask myself as to when I'm going to die. I used to cry, because my question is the same as to when this disease will end. If there is no cure, then the disease is sending a serious message to the people. The disease might be coming from the creator himself, I am not sure, but it might be coming from Him because many people suffer from this disease and this disease is all over the world.

The statement from the school youth about performing *kupitakufa* with or without *jeito*/condom generated an argument, and made people laugh at such a question: “ha, ha if you use *jeito* you are not doing anything it is a joke”. Such a response makes it evidently clear that there is no way *kupitakufa* can be performed with *jeito*. The use of condom prevents the flow of fluids and healing, because the performance is not about sex, but about the flow of fluids, and of semen that require flesh to flesh contact to allow cleansing and healing. Sexual intercourse is culturally seen as ‘hot’ (Kring-Ney 2009:492), particularly when one is contaminated by some disease or possessed by evil spirits. Diseases must be ‘cooled down’ with treatments that include exchange of fluids. Apart from not understanding the meaning of rituals, little has been done to see how best to adapt traditions and rituals or shifting social and spiritual realities or to make decisions necessary for prevention of HIV and AIDS.

One of the crucial questions asked by students in relation to AIDS was the issue of menstruation as, “(...) man die first because men do not menstruate, therefore a man

cannot clean himself as women do” and “I would want to know if menstruation release can take out virus from a woman’s body”.

The questions above revolve around the perceptions of menstruation. The question implies that menstruation has the power of destroying the AIDS virus. The reason why students ask this question is because people in the community view menstruation as a process of cleansing diseases. The ‘opportunity’ for women to menstruate, gives them power to clean themselves every time they menstruate. However, menstruation is also viewed as having power of polluting and able to produce other type of dirt (Green 1999a; 1999b; Kring-Ney 2009) and can in this case be dangerous for transmitting STDs and HIV infection. According to the members of the community, menstruation is synonymous with health and this was made clear from other studies that discussed menstruation as something negative—a "curse" or a failure to conceive—or as a positive part of the reproductive process to be celebrated as evidence of fertility, has long been a universal concern (Rennie et al 1995; Buckley and Gottlieb, 1998). Menstruation is essential for reproducing and maintaining a healthy equilibrium. It is a means of conveying a feminine social role through initiation rites which although not in the whole country is still performed in most of Mozambique.

According to Buckley and Gottlieb (1998) menstruation should be considered within a particular cultural context because its meanings are “ambiguous and multivalent”. In Maringue and Dondo menstrual blood expresses not only femininity for some women, but also reaffirms acceptance of the female social role. Menstruation is also seen as form of purification rather than pollution and also determines that women live longer

than men as one of the community leaders explained that, “(...) man die first because he has no menstruation, he cannot clean himself as women do”.

About Elderly Woman Being HIV Positive

The issue of elderly women being infected with HIV was raised. This was challenging and surprising because they are considered to be no longer sexually active. One participant in a focus group discussion said:

... there is a new phenomenon emerging. It is new among us to see a woman at the age of 60, 70 years being diagnosed HIV-positive. Where do they get the virus if they stay alone? Where was the disease during previous years? Old women are no longer engaged in sexual intercourse but are infected with HIV. This is the reason why people raise questions about the reality of HIV. People mix the biomedical interpretation with the traditional explanations. When we go to the hospital they say it is HIV, and when we go to the traditional healers they say it is “*phiringaniso*” ... I do not know how it is transmitted. (December, 2008)

Getting infected by HIV at an advanced age is a complicated issue, as some of the women find it difficult to give a proper explanation on how they got infected and they provide explanations such as one an elderly woman gave during the interview that “it was through a dream”.

Nevertheless, rituals provide insight into relationships among the livings and the dead because rituals allow communications between the spirits of the ancestors and this is conducted through an understanding and appreciation of life and culture. Rituals also encourage creativity and imagination that lead to the comprehension of the moral order and they inspire the search for truth and wisdom' (Airhihenbuwa 1995; Akinjogbin 1987/1990). The approach on rituals in this study intends to show that for HIV and AIDS education and prevention programs to succeed, they must be informed by culture because people have different ways of perceiving the world and this depends on the culture in their surrounding. However, even people from the same surrounding can still differ in how they interpret the meanings of actions taken and this applies to HIV/AIDS.

Prospects and Challenges of Rituals in HIV/AIDS Prevention Interventions

The exploration of rituals led to the discussion of different roles and activities that sex and sexuality play in the communities in Dondo and Maringue. The findings from this study suggest that research on sex and sexuality has a low priority in the social science (Lewis et al. 2001). However, sex and sexuality in the community has different meanings and roles that have to be taken into consideration when organizing HIV/AIDS prevention interventions. Thus, sex is seen and perceived as having social function and it informs gender identity. From the findings of this study sex is regulated by the family and society because it plays different roles. In Dondo and Maringue people see and perceive marriage as a union for the production of children, being so sex has a social function of procreation. The life of married people is driven by both the families of the married couple and societal sexual regulations. Thus, after childbirth

a couple must abstain from sex until *pitamabzwade* has been performed unless the wife authorizes the husband to have sex with the other wife (wives) in case of polygamous marriage. People believe that failure to perform the ritual will cause disease to the new born and the parents.

However, sex can play a role of social interaction that is reflected in the marriage which is authorized by family and extended to societal structures including state institutions. The husband and wife play a role in different cycle in the life of the couple since they begin to abide by certain social norms and expectations and trust (Ntseane 2004:11). *Kupitamabzwade*, *kupitakufa* and *phiringaniso* emphasize a relationship based on good parenting and community responsibility. Thus, parents have influence and take decision on sexual relation among the couple. Parents decide on the time “*kupitamabzwade*” should be performed. Culturally, breastfeeding is done for a period of two years and currently a minimum period of six months; and during this time the lactating mother is not supposed to have sex with her husband. This function is also reflected on *kupitakufa* ritual since people have to avoid sexual practice during the mourning period until the leader of the ceremony allows people to resume sexual intercourse.

Sex is a medium of exchange as reflected in the birthright inheritance of widow and children’s including her belongings and this is practiced within communities to ensure social responsibility. In Dondo and Maringue it is common to support a widow and her children by the deceased husband’s family. Thus the male who take the responsibility becomes a husband and father to the children. In order to legitimize the practice of inheritance *kupitakufa* ceremony must be performed.

Due to the economic hardships, unemployment and poverty it was mentioned that young girls engaged themselves in unprotected sexual practices with older men in exchange for money and other basic services. As mentioned, sex is a medium of an exchange and this is evident in the behaviour around prostitution and sex workers as a means of survival. But culturally people believe that sex has a function of cleansing and healing. This sexual practice according to Ntseane (2004:12) “by the different cultural dimension of sexuality is inter-generational sex or between young women or girls with an older male sex partner”.

Through *kupitakufa* or *kupitamoto* blood that is hot is cooled. There is the belief that a person's blood can be ‘hot’ referring to semen or orgasm of an individual person can be in conditions be polluted and become harmful to people. For example, widows and widowers are said to be ‘hot’ during the mourning period or during the woman's menstruation period and after abortion. Hotness is said to result from sexual behaviour that have power to affect other people's bodies during sexual intercourse, therefore, require cleansing that would cool down the body of the person polluted or stricken by “*phiringaniso*” and if the cleaning processes is ignored, that particular person may die. In both districts people reported the use of African medicine (roots and herbs) for treating sexually transmitted infections, purifying dirty blood and casting out the “*mbepho*” or the evil spirits. Literature (Mutula 2002; Monteiro 2003) on traditional medicine, show that local herbs, roots, barks and leaves from wild forests have been identified as sources in traditional healing and as cure for different diseases including improving the immune system in case of those who suffer from AIDS. The social power and function of sex as cleansing and healing is located in the family in enforcing

all prevention and curative health aspects. Nevertheless sex has also religious or spirituality functions.

The connection of the dead and the living through sex gives a different angle to culture. Western Christianity ignores specific cultural practices represented by religions or spirituality in some community and views them as stumbling blocks towards effective measures against HIV/AIDS. The argument is that polygamy and adultery were reported as common even among those who attend churches (Christian churches) and these practices are viewed as contributing facts to the spread of HIV/AIDS. This is an evident to the arguments provided by many researchers that cultural performance encourages the spread of HIV/AIDS. Other than the issue of multiple sexual partners, rituals like *kupitakufa* are said to be tools in the spread of HIV. The performance is risky, but the danger remains in the procedures or the manner in which the performance is carried out. People do not get tested for HIV/AIDS before performing the ritual and therefore the performance become a tool for transmitting the virus.

Nevertheless, church goers are discouraged to use condom since the Christian doctrine is against condom use. Thus prevention campaigns must find a way to include important aspects of the society that can benefit messages about HIV/AIDS prevention, and this can be done through involving them as major role players in the HIV/AIDS field.

The Meaning of Sex in Cultural Practices

Sex also plays a role of controlling and repressing people; from a gender perspective, the sexual practices and behaviour described in this study fit in the definition of sexuality provided by Jackson (2002: p 88) who asserts that “sexuality refers to the aspects of gender identity that relate to sex”. As far as sexual behaviour is concerned with men in many societies they can be proud of having multiple partners because of the relationship between power and sexuality. But for women sex is predominantly about pleasing men, essentially for husband and for having babies. Hence sexuality often refers to male needs and desires, while women’s sexuality is not recognized, feared and repressed. From the findings in this study dressing code was seen as form of oppression or control mainly from the youth perspective to others (the adults) as interpreted and understood within cultural norms when they refer to women. Woman who wear shorter dresses or skirts are viewed as whore or offending the society. Other than this claim, woman who exposed their bodies were also accused for provoking men’s sexual behaviour. The power manifestation among different generation has also impact on silence and this is viewed as one of reasons that cause of HIV infection increase.

CHAPTER VIII: CONCLUSION AND RECOMMENDATIONS

This thesis reported issues concerning the continuous spread of HIV/AIDS in Mozambique using Dondo and Maringue districts in Sofala Province⁴⁰ as field sites of study. It begun by introducing the purpose of the research study as the socio-cultural reasons for the persisting spread of HIV/AIDS and the government’s failure to recognise the significance of the use of local cultural practices in health-related issues

⁴⁰ Dondo and Maringue are situated in Sofala Province as presented in the map in Annexure A and Annexure B

including HIV/AIDS prevention interventions. This thesis argued that the failure to recognise the significance of cultural practices in the health system was due to the domination of the biomedical approach that is dominated by the western culture in the public health system. Due to the persistence in the use of cultural practices in health issues, the public health system on HIV/AIDS prevention interventions becomes ineffective.

People accept the biomedical approach, but their persistence in the use of local cultural practices including African medicine gives one an opportunity to conclude that the acceptance of HIV/AIDS biomedical approach is partial, and therefore, hinder HIV/AIDS prevention intervention strategies to be effective. A number of cultural practices like the use of local concepts for certain disease such as *xirombo* and *phiringaniso* and ritual performance such as *kupitakufa*, *kupitamabzwade*, *kupitamoto*, etc has been emphasised as the major cultural practice in health issues including practices around HIV/AIDS prevention interventions. The introductory part of this thesis provided definitions of each of these concepts and rituals.

Other than the introduction on the reasons behind the continuous spread of HIV/AIDS, the introduction talked of the failure to recognise the possible positive impact in the integration of local cultural practices into the public health system; the issue of faithfulness to a single partner, condom use and delay in sexual debut as the principal measures in preventions strategy. In bringing in the impact of local cultural practices on HIV/AIDS prevention interventions, it was introduced that the use of local cultural practices appear as a form of resistance to the HIV/AIDS biomedical approach and its prevention intervention strategies.

Although the biomedical approach is seen as dominating in public health, the local people's favour of the local cultural practices when compared with that of the biomedical practice give a credit to the local cultural practices to be the dominant in the local health practice particularly in the case of rural environment of Mozambique (mainly Maringue) where health sector is still extremely poor, and the communities first consult healers before they look for any kind of public health services where they are available. The introductory part of this thesis recommended the call for an effective HIV/AIDS strategy and declared that this would be made possible if the prevention measures take into account both biomedical approach and the local cultural practices in an integrated approach in the public health system.

Conclusion on the Literature Review and Theoretical Framework

As guiding principles of this study, the thesis reviewed the literature and theories relevant to the impact of socio-cultural practices in HIV/AIDS pandemic and prevention interventions. This chapter began by providing an overview of HIV/AIDS as a global problem, but with a major impact among developing countries, especially African countries. Africa has a large number of people infected with HIV/AIDS. The fact that HIV/AIDS is considered as a health and development problem was discussed as the reason behind HIV/AIDS being concentrated in poor countries. From this argument, it was recommended that the situation requires a serious attention and intervention, with an argument of that the current approaches are not compatible with the local culture and therefore not effective.

In this chapter, the thesis discussed different conceptualisations of HIV/AIDS prevention interventions strategies bringing in the discussion on the global conflict approach of HIV/AIDS with the local perspectives. This discussion emphasized the issue that HIV/AIDS is not only a socio-cultural issue, which is the focus in this thesis; it is also an economic and political issue. This is to say that development, poverty and political decisions including relevant policies on HIV/AIDS play a role in the status of HIV/AIDS issue in each country. African countries were declared to be experiencing difficulties in solving the problem of HIV/AIDS when compared with European countries due to their economic and the political status. For example, African countries experience the impact of HIV/AIDS 'equal to their economic and political statuses'.

There are a number of studies which look at the impact of socio-cultural status of African countries on HIV/AIDS interventions, not omitting the economic and political status as a way of pinpointing the problem behind the continuous spread of HIV/AIDS in African countries. For example, McFadden (1992) argues that the problem lie at the tendency of viewing the issue of HIV/AIDS as a medical problem with emphasis on sero-epidemiology, with less attention on the historical, social and cultural factors. Bulmer (1993) argues that the problem with continuous spread of HIV/AIDS is that African countries are using standardised western tools to analyse their situation, while the tools are incompatible with the economic, social, cultural and political statuses of the countries.

HIV/AIDS prevention programmes were implemented in African countries but were ineffective. As a result, some African countries like Botswana and South Africa

organized campaigns against HIV/AIDS focusing on local issue and using local approaches (Heald 2002).

Few researchers have focused on the use of traditional methods for preventing disease including HIV/AIDS in the Mozambique, e.g., Macamo (2003), Arnaldo (2003), UNAIDS (2002), Casimiro and Andrade et al. (2001), Arthur et al. (1993) and Loforte (2003) identifying some cultural practices that are said to be contributing to the spread of HIV/AIDS in Mozambique. It was presented in this chapter that many Chagga—the dominant ethnic group in the Kilimanjaro region—viewed the pandemic as a curse from the ancestors (Setel 1996). The view is not ‘scientific’ but based on mythical explanations. This kind of local perspective forms the basis of social scientists’ view as the reasons behind continuous spread of HIV/AIDS (Caldwells 1989). It is still a taboo to speak about HIV/AIDS in some areas of Malawi due to discrimination of people infected by the disease (Pembrey 2009). Cultural practices such as *kulowa kufa*, *bzwade* and other related ritual performance that involves sexual intercourse were said to be the culprit behind the continuous spread of HIV/AIDS (Kadzandira & Zisiyana 2006)

According to the Agenda 2025 Policy (2003) the prevalence of HIV infection in Mozambique is increasing at a faster with the failure for the policy to pay attention to the role of the cultural practices. Santos & Arthur (1993), Casimiro (2002), Loforte (2003), Macamo (2003) and Arnaldo (2003) argue that cultural practices such as birth, death and initiation rites have impact on the spread of HIV/AIDS. Other than cultural practice, Santos & Arthur (1993) viewed the practice of unsafe sex with different partners as the culprit behind this problem, coupled with the lack of the use of condoms

(Casimiro 2002). The above empirical data assists towards the understanding of the meanings and interpretations from the local people on HIV/AIDS prevention interventions.

The study was also guided by the two basic theories—that of resistance and the socio-ecological theory. It was argued that the HIV/AIDS brought cultural conflict between the biomedical approach and the local cultural approach, where people find themselves in a situation where they have to accept or reject one or all of the two conflicting cultures. The situation required an understanding of the theory of resistance, and where western ideologies became dominant culture as imposed on African people, but its domination failed to eradicate local cultural practices. Local people acknowledged the dominating cultural practices, but continued with their local cultural practices and their persistence in the use of local culture conveys both overt and covert messages to the dominant culture and this could be understood as a form of ‘resisting’ behaviour - resistance is an action that is taken towards rejecting western cultural practice.

The socio-ecological theory was used to demonstrate the need of viewing health issues from different social environmental factors and to interpret the complexity of a society that emphasised actions and reflective practices that integrate a personal action to all dimensions of the society. This is about the social and physical settings that contextualise a person as well as the interaction between a person and social settings in a holistic approach. The ecological theory assisted in assessing the central concern in a holistic way, rather than concentrating on a single context of the society. The reason behind the use of socio-ecological theory was to look at the central concern in order to

identify the interrelatedness of the structures of the society and how these structures influence each other.

Conclusion on Research methodology

Ethnography was used as the major research methodology in this study by build a rapport with research participants as well as the application of different research strategies for evaluating and validating different sources. The narrative stories presented by the people of Dondo and Maringue became the medium for the construction of the meaning of the practices—ethno-methodology and the relationship between the symbolic and the meaning of the practices were obtained through an exploration of the underlying symbolic systems of the structure of the phrases during their story telling. Data was collected from different target groups and actors such as NGOs, health professional and administrators, teachers, youth, individual members of the communities, traditional and community leaders, religious groups and people living with AIDS. Self generated data technique, focus group discussions, narratives, semi-structured formal and informal interviews and participant observation were also used for data collection. As an additional strategy I used the preliminary results collected and used it to generate a debate in discussion groups. Snowballing was used in sampling where the interrelatedness on each actor could create a link to other actors of culture in the community. Dondo and Maringue districts were used as fieldwork sites to gather data on the spread of HIV in Mozambique. The reason for choosing these districts was due to the two districts geographical position although they are situated in the same province. For analysis of the data collected, the interpretative approach was

used to represent the knowledge that describes the culture of people living in Dondo and Maringue.

Conclusion on Overview of the Study Sites

Mozambique is one of the poorest countries in the world with high levels of inequality and inadequate distribution of resources. This problem does not only emanate from the economic status of the country, but from the lack of a proper health system. People have, for example, to walk for long distances to access health services. This chapter narrated the healthcare system in Mozambique within which the HIV prevention interventions take place, where the informal prevention practices occur, and how the HIV/AIDS prevention interventions and informal prevention interventions confront each other. According to this study, informal prevention intervention is central in determining the effectiveness of the biomedical interpretation of HIV/AIDS, including its prevention interventions strategies. But these informal preventions were still not formally recognised and even acknowledged.

The narrative technique was used to describe the historical emergence of both Dondo and Maringue. The history of Dondo and Maringue were discussed in order to highlight their cultural environment, and thus contextual factors that influence the risk of HIV and this discussion included factors around inadequate social services, lack of public infrastructures, ineffective or lack of education around health, insufficiency in expertise resources, ineffective communication, use of different languages that are spoken by the people, different perceptions that are determined by cultures, cultural

practices, gender inequalities, ethnic, economic differences, lack of political will, and weak national-strategy on HIV prevention.

The healthcare system in Mozambique is provided by the “Ministério de Saúde” (MISAU) through hospitals, health centres and health posts. Centres that serve rural areas differ from those in the cities. The problem is a shortage of resources in the former. Healers or the *curandeiros* play an important role in providing healthcare to both rural and urban populations. Since a large number of the population do not have access to the public health services, people consult with *curandeiros* as their major source of health care.

Lack of resources and health facilities in Dondo and Maringue was a concern in this chapter. Other than the public-health facilities, NGOs were able to visit people with AIDS at their homes, but the situation was not conducive for the NGOs to assist the people; and neither is it comfortable for such person. Many of these people are poor, and their houses do not meet requirements to shelter a sick person. However, there were additional healthcare facilities, including voluntary counselling and testing (VCT) facilities in the districts, but resources still could not cater the entire population.

Conclusion about the Impact of HIV/AIDS on youth

This chapter discussed the reasons why the youth are heavily affected by HIV/AIDS, including issues of accessing information about sex, sexuality, and HIV/AIDS including its prevention interventions from different contexts of the society. The

discussion around the issue of accessing information related to what parents and other groups said about the meaning and the need of initiation rites like *kulangiwa*, and how these rites of passage have been transformed from one phase to the next and eroded. The chapter also discussed different point of view and concern about young people in relation to the knowledge and behaviour as expressed by the school youth. The concern is that the youth is exposed to the risks of HIV and AIDS when compared to older age groups, because they are at the stage when they experiment with new things.

The chapter also discussed points of view provided by the parents that young people are at risk of HIV/AIDS because of the manner in which they conduct themselves; young people do not respect the local culture and values anymore, and therefore, youth understand little about the culture of their ancestors. Parents did not blame the youth entirely; they argue on the need of formal and consistent teaching or socialisation on children, which was currently unavailable to assist youth in constructing the meaning of their lives in order to make decisions that cannot jeopardise their future.

It was declared that children's behaviour is influenced by the environment within which they are socialised. The fieldwork showed that young people acquire knowledge about their society including HIV/AIDS from different spheres of the society with each sphere influenced by its own culture and cultural practices some of which are in conflict. Dondo and Maringue communities are multi-cultural and comprised of both western and local culture, each with its own cultural practice. Each of these cultural practices has influence on individuals. Besides being exposed to different cultures and cultural practices, young people are socialised differently depending on the approach each sphere takes. Although parents are central in influencing how children view the

world, young people also learn and obtain knowledge from different spheres, including global, national (Mozambique), societal (Dondo/ Maringue), and local (local areas including individual households) where children get information about sex and sexuality, including information about HIV/AIDS and prevention intervention strategies. The issue of acquiring knowledge from different spheres that are influenced by different cultures meant that misunderstanding from conflicting culture were inevitable. The situation is problematic; because children receive knowledge that is inconsistent, and that they use this knowledge in making their daily decision.

Initiation ritual was also viewed as a tool towards reinforcing HIV prevention among girls and boys. Parents were of the view that, the formal public education, such as schools, public health institutions and NGOs dominated by western culture, was not doing enough in building morals in young people and this failure is seen as central to the spread of HIV/AIDS. *Kulangiwa* ritual, according to them, should be encouraged for teaching young people how to conduct themselves. Parents also discussed how the rites of passage benefited the youth, the parents and the communities. Parents were able to control the behaviour of their children through the *kulangiwa* rite of passage. Children would in turn know the consequences of disobeying the rules they had learned. This cultural practice benefitted both the children and the whole society.

In addition, the community blamed the war for forcing girls into sexual intercourse at an early age, and early marriage because of rape and kidnap. The transformation from one culture to the next resulted in people abandoning their own customs, thereby, eradicating the moral values regulating marriage.

HIV/AIDS prevention intervention strategies should accept the cultural practice framework of local people and work in partnership with them. This is important for local people especially young people who fall the risk of getting HIV/AIDS.

Conclusion on HIV/AIDS Prevention Interventions within the Contextual Realities in Dondo and Maringue Districts

In the current HIV/AIDS environment, realistic and challenging facts exist. In demonstrating these facts, a local health conceptual framework was discussed in the context of HIV/AIDS, including its implication to the HIV/AIDS prevention. This conceptual framework contains theory and practice. The framework discussed the local concepts and practices (rituals) used in the local health, including the functions and the meanings of these concepts and practices to the people. A conception of this theory (concepts) and practice (rituals) provided an understanding of how local people organize and make sense of their daily lives. This conception can be used as a guiding principle for effective adoption of HIV/AIDS prevention interventions, including decisions around health in general.

The current situation is too complex and demands that the public/government allow people to assess their socio-cultural systems not currently accommodated in biomedical interpretation of HIV/AIDS prevention. In order to demonstrate this complexity, this study focused on the meaning of sex and sexuality and the understanding of HIV/AIDS prevention interventions in the context of socio-cultural dimension among the people in Dondo and Maringue. In this study of local cultural concepts as well as rituals were used to interpret the behaviour and local meanings to sex and sexuality, and disease, including HIV/AIDS. Local people conceptualised their socio-cultural sphere using

cultural systems and practices. These interpretations differed from the western cultural perspectives. The ability of local people to interpret their socio-cultural dimension differently from the western perceptive makes western biomedical interpretation less meaningful to the local people.

Dondo and Maringue communities are not only aware of the different kinds of HIV/AIDS prevention interventions; they also mentioned diverse reasons as basis for HIV infection. Actions such as lack of sustainable activities on prevention resulted from corruption, attitudes, fragility on implementation of HIV/AIDS education policy and contradictory approaches, because of the failure to select different age groups when disseminating messages on prevention; the prevention interventions decontextualized from socio-cultural environment; lack of power among local leaders, the dominant western scientific knowledge, which strives on abstracting formulation and separation from the lives of communities make a difficult dialogue among the actors on prevention in communities. The fact is that local knowledge is perceived as residual, traditional and backward way of life; and people find themselves left out of the HIV/AIDS prevention interventions.

HIV/AIDS is a challenge even to those who act on prevention interventions (mainly activists from NGOs) since the majority of them are from low and middle income backgrounds. People who work as volunteers expect to earn some money to sustain their families, including material and financial conditions for providing service to people affected with the disease. Thus, stories about corruption also embrace moral or sexual activities that can result in increasing of HIV infection. As a consequence some NGOs fail to develop proper relationship with the communities they serve because

people develop attitudes against the service providers, and as a result, actions on prevention interventions for communities become invisible.

Meanwhile, government fails to regulate media especially TV which exposes adolescents to a significantly increased number of explicit sexual messages and glamorous images. TV programmes have influence on language, for example, the use of the term “*matreco*” as a powerful expression to tell people that they are backward becomes the reason adults feel shame to give advice to young people.

The perception about women’s dressing code reflects the gender inequalities and the powerless relationships among men and women. People in Dondo and Maringue interpret the women’s dressing styles as suggesting that sex is available to men. Gender and culture have emerged as the two key issues in the health status of women and men. Gender differences in opportunities shapes women’s and men’s choices and expectations, and, in turn, affects their exposure to various risks including infection on HIV. Data show that sex and sexuality are socially constructed because of the societal norms that are in place to socialize, and to define functions. The cultural dimension of sex regulates and controls sexual behaviour.

People perceive that government as failing to make policy available in order to control prostitution and *barracas* which are continuously emerging resulting in HIV infection increase. Poverty with its accompanying side-effects such as prostitution, poor living conditions, poor education and poor healthcare are the major contributing factors to the current spread of HIV/AIDS in Dondo and Maringue. For the people, other factors include religious groups with claims of faith healing with claims that they can cure

AIDS. This kind of discourse makes people ignore the biomedical approach in HIV/AIDS prevention programmes. The fact that AIDS is a disease that came from outside or being a disease of “*others*” makes people think it is easy to tackle as people have a view of that government can easily deal with these kinds of situations. Furthermore, sexually transmitted diseases and AIDS are always associated with those who have different sexual partners and prostitutes. During the group discussions with the members of the communities of Dondo and Maringue, people withstood each other on the perception of that HIV/AIDS is spread by professional people who travel outside the country and bring in the disease to the home country.

In this study, sex meant a process of controlling and repressing people according to their gender relations. From the findings in this study dressing code was seen as form of oppression or control mainly from the youth perspective to others (the adults) as interpreted and understood within cultural norms when they refer to women. Women who wore short dresses or skirts were viewed as whores or offending the society. Other than this claim, women who exposed their bodies were also accused for provoking men’s sexual behaviour, and therefore, women’s dressing style were being reviewed. While sex means control and repression within gender perspective, language plays an opposite role where when youth use expressions from outside their local cultural context to control the power relations with the adults. Faith healing is also seen as one of the reasons that fuel the pandemic since it has been used to delay AIDS interventions strategies. Taboos and myths were used as a form of communication among adults with children, from children perspective is understood as silence which

exacerbate the HIV infection among youth who find support from friends and peers. This notion from young people is contradicting with the parents' point of view

Conclusion on Indigenous Knowledge and Cultural Practices in the Context of HIV/AIDS Prevention interventions

Although the public adopted HIV/AIDS prevention interventions is acknowledged in Dondo and Maringue, cultural practices such as *xirombo*, *phiringaniso*, *kupitakufa*, *kupitamabzwade*, *kupitamoto* and *xitonga* are used in dealing with health issues including HIV/AIDS. The HIV/AIDS prevention interventions were lightly accepted in Dondo and Maringue, because the biomedical approach has little meaning to the people's lives. The partial acknowledgement of HIV prevention intervention strategies was due the continued dominance of local cultural practices for dealing with diseases among local people. The persistence in the use of cultural practices questions the compatibility of the implemented HIV/AIDS prevention interventions to the local culture and translates the cultural practices into a form of resistance against the implemented prevention interventions.

The chapter brings to context the local expertises which are able not only to construct local concepts about diseases including HIV/*xirombo* and AIDS/*phiringaniso*. The chapter analysed the cultural practices in the context of HIV/AIDS prevention, where local cultural concepts such as *xirombo* and *phiringaniso*, and rituals such as *kupitakufa*, *kupitamabzwade*, *kupitamoto* and *xitonga* were used as local strategies for prevention from diseases including HIV/AIDS among local people. These local cultural concepts and rituals have not been recognised in the public health. This thesis

argues that the incorporation of cultural health practices into the public health sector is required as method for dealing with health issues including HIV/AIDS prevention.

The situation resulted in the conflict of cultures in the society as the HIV/AIDS prevention strategies were adopted from the western biomedicine, while the local cultural practices were continuously used within the traditional culture. The two approaches clashed and creating a conflict in health practices. The incompatibility of the use of biomedical approach among local people did not start with HIV/AIDS concern, but earlier during the introduction of biomedicine among the local people. Although the two approaches share a health concern, they both use different methods and impact people differently. It was argued that the cultural health approach was preferred when compared to the biomedical approach. The reason for this preferences was due to the local people's faith in their cultural practices and related belief system.

The problem of conflict of cultures did not only emanate from the people's faith in cultural health practices, but also from the dominance of the cultural health practices at the local level. The fact that people prefer the use of cultural practices means that these practices are meaningful in their lives. The biomedical approach has almost been rejected by the local people and this is one of the reasons why this thesis suggests the incorporation of cultural health practices into the public health system as a way of stimulating people to fully recognise the value of both biomedical approach and local cultural practices.

The continuation in neglecting local cultural practices will mean that the public health system will remain ineffective, and the same applies to the current HIV/AIDS prevention intervention methods that are currently incompatible with the local culture.

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